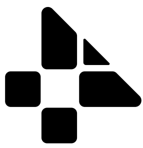

NL Health Services

Maternal Serum Screen Requisition

HCN: ______________________

Province/Territory: __________ Expiry: __________

Name: ______________________

Date of Birth: __________ Sex: ☐ M ☐ F ☐ UN

Mailing Address: ______________________

City: ______________________

Province/Territory: __________ Postal Code: __________

Telephone: (Indicate Preferred) ☐ Home: __________

☐ Cell: __________ ☐ Work: __________

Ordering Provider's Name: ______________________

Clinic Name: ______________________

Mailing Address: ______________________

City: ______________________

Province/Territory: __________ Postal Code: __________

Telephone: __________ Fax: __________

Signature: __________ Date: __________

Clinic Stamp:(include fax, provider and mnemonics)

Ordering Provider's Meditech Mnemonic: __________

EMR Clinic Mnemonic: __________

COPY TO PROVIDER: __________

Collect 2 SST: Centrifuge after 30 minutes of collection, Separate the serum and freeze 2 aliquots immediately. The entire process from collection to freezing should be completed within one hour. Send the two frozen samples with completed requisition to: Health Science Centre - Special Immunochemistry Laboratory, 300 Prince Philip Drive, St. John's, NL A1B 3V6
Tel:709-777-6474 Fax:709-777-2176

Race: ☐ Caucasian ☐ Black ☐ Asian ☐ Other (specify): __________ Collection Date (YYYY/MON/DD): __________

This patient has received counselling about the purpose of this test and possible implications of results.

ACCURATE AND COMPLETE INFORMATION IS ESSENTIAL FOR VALID INTERPRETATION

1. Gestational age: **Must be between 15 and 20 weeks gestation at the time of blood collection**

Date of last menstrual period (YYYY/MON/DD): __________ Estimated due date (YYYY/MON/DD): __________

2. Does this patient have insulin dependent diabetes mellitus? ☐ Yes ☐ No (Note: Not Gestational Diabetes)

3. Is this a twin/multiple pregnancy? ☐ Yes ☐ No ☐ Unknown

4. Patient's weight__________ lbs or __________ Kgs (at most recent prenatal appointment)

5. If an ultrasound has been performed provide measurements and gestational age by ultrasound:

Date of ultrasound (YYYY/MON/DD): __________ Crown Rump Length (CRL) ______ mm or Biparietal Diameter (BPD) ______ mm

Gestational Age (GA): __________ weeks __________ days

6. Has patient had Chorionic Villi Sampling (CVS) or amniocentesis during this pregnancy? ☐ Yes ☐ No

Note: If karyotyping has been done, only open Spina Bifida will be reported

7. Has this patient had a previous **positive screen** report during this pregnancy? ☐ Yes ☐ No

Date of collection (YYYY/MON/DD): __________ **Time (HH:MM):** __________

Collector's Name: ______________________ Signature: ______________________

Collector's Notes: