Saskatchewan Health Authority

Roy Romanow Provincial Laboratory
Maternal Serum Screen Requisition

Patient Name ______________________ ______________________ Last Name First Name	Patient HSN Postal Code
Birthdate ☐☐ ☐☐ ☐☐ D D M M Y Y	Collection Date D / M / Y Collection Time H / M
Physician name (include First Name and Middle Initial)	Physician MCIB#

Return Address (Physician's Office) Please include phone number)

Physician Ph. #: ______________________ Fax #: ______________________

In addition to mail/courier, please copy to: Dr.'s Name ______________________

Ph. #: (_______) ______________________ Fax #: (__________) ______________________

It is **ESSENTIAL** to provide all information required on this form for optimum turn-around-time.

Specimen Type: NOTE: Neither First Trimester nor Second Trimester biochemistry or First Trimester ultrasound alone is sufficiently sensitive to be used as the only screening test. First and Second biochemistry or biochemical testing combined with currently accredited ultrasound is recommended.

Serum:

1. Integrated Serum Screen (1st and 2nd Trimester combined) ☐ **(Preferred Option)**

(The patient will have **TWO** blood samples done and **ONE** report will be issued, after the second sample)

2. First Trimester Screen (11-13 weeks) (PAPP-A, Free BHCG) ☐ NT/US – Pending Y / N
3. Second Trimester Screen (15-20 weeks) (AFP, uE3, TBHCG, DIA) ☐ (Date of U/S? ___________)
4. Second Trimester-AFP only (if 1st Trimester is done). (15-20 weeks) ☐

Amniotic Fluid:
AFP only ☐
(15-20 weeks)

For neural tube defect screening only)

**If ultrasound is desired a separate requisition must be sent to an accredited facility **

Clinical Information:

Last Menstrual Period Date ☐☐ ☐☐ ☐☐
D D M M Y Y

IVF: yes ☐ no ☐

Gravida ________ Para _______

Current Weight __________ lbs __________kg

LMP: certain ☐ uncertain ☐ unknown ☐

Insulin dependent diabetic: yes ☐ no ☐

Antepartum Bleeding: yes ☐ no ☐

Is this a multiple gestation pregnancy:

yes ☐ no ☐ unknown ☐

Ultrasound Visit: yes ☐ no ☐ pending ☐

Date ultrasound performed: ________________

If yes – location ______________________

*Please send copy of ultrasound report with requisition if possible.

Measurements from U/S: CRL ______________mm BPD: ______________mm NT: ____________mm

Average gestational age by above U/S:

____ weeks ____ days

FMF ID#: _____________ (Required with NT u/s)

Racial origin: Caucasian ☐ Afro Canadian ☐ First Nations ☐ Asian ☐

Other (specify) ______________________________________

*Racial origin is necessary for risk calculation.

First Trimester send in top copy. **Second Trimester send in second copy**

Sample Collection:

1. Collect 2 mL serum. Separate from cells within two hours.
2. Send the sample on an ice pack to the Saskatchewan Disease Control Laboratory within 24 hours of collection.

Please remember to include all information including the patient's postal code. The postal code is used in Maternal Serum Screen program evaluation.

Alpha-Fetoprotein in Amniotic Fluid (AFP):

Sample Collection:

1. Collect 1 mL amniotic fluid.
2. Refrigerate at 2-8 degrees Celsius and transport on ice packs, within 24 hours of collection.