



**North York General**  
 MSS Laboratory, 4001 Leslie Street 3rd  
 Floor Southeast  
 Toronto ON M2K 1E1 Fax: (416) 756-6108

**Multiple Marker Screening (MMS) Requisition – for Down Syndrome, Trisomy 18 and Open Neural Tube Defect (ONTD)**

- Prenatal screening requires patient education and should proceed only with informed choice of the patient.
- Nuchal Translucency (NT) ultrasounds need to be ordered by the health care professional. **The MMS Laboratory does not make arrangements for the NT ultrasound.**
- The blood sample can be drawn at any community lab **after** the NT ultrasound, ideally on the same day.

\* Name: \_\_\_\_\_  
(SURNAME) (GIVEN)

\* Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(YYYY) (MM) (DD)

\* Health Card #: \_\_\_\_\_

\* Address: \_\_\_\_\_

\* Postal Code: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Obtain this requisition online at: [www.prenatalscreeningontario.ca](http://www.prenatalscreeningontario.ca)

**Test Requested (choose one only) Clinical Information (please complete all sections)**

**Only select eFTS or STS below if singleton pregnancy and:**

- NIPT has not been ordered in this pregnancy
- NIPT has been ordered, but has been uninformative

**Enhanced First Trimester Screening (eFTS)**  
 (eFTS: NT, PAPP, FBHCG, PIGF, AFP)  
*[CRL 45-84 mm corresponding to ~11w2d and 13w3d]. Requires nuchal translucency (NT) ultrasound and blood sample.*

**Second Trimester Screening (STS)**  
 (AFP, hCG, UE3, inhibin A)  
*[14w0d-20w6d] Ultrasound dating preferred to LMP dating; record ultrasound information below, if available. Requires blood sample only.*

**NT + Second Trimester Screening (NT + STS) (vanishing twin/co-twin demise only)**  
*Requires NT ultrasound [11w2d-13w3d] and second trimester blood sample [14w0d-20w6d]. Blood draw can be done 8 weeks after demise. This blood sample can be drawn after: \_\_\_\_\_ (date).*

**Maternal Serum AFP only [15w0d - 20w6d]**  
*Available for ONTD screening only when geographical location or clinical factors limit high-quality anatomy ultrasound screening.*

Above criteria met

**\*Accurate information is necessary for valid interpretation\***

**Racial origin of oocyte:**  
 (check all that apply)  
 \*only broad racial origins are needed for screening marker adjustment purposes

Asian  
 South Asian  
 Black  
 Indigenous  
 White  
 Other: \_\_\_\_\_

**Weight** \_\_\_\_\_ kg or lbs

**Last Menstrual Period (LMP):**  
 \_\_\_\_\_  
 (YYYY/MM/DD)

**Was this patient on insulin prior to pregnancy?** Yes

(Note: not gestational diabetes)

**Smoked cigarettes EVER during this pregnancy?** Yes

**Complete the following if this is an IVF pregnancy**

Egg Donor Birth Date (even if patient is donor): \_\_\_\_\_ (YYYY/MM/DD)

Egg Harvest Date : \_\_\_\_\_ (YYYY/MM/DD)

**Ultrasound (U/S) Information** Sonographer or ordering provider to complete. Identify U/S operator code only if doing NT Scan.

Viable twin pregnancy identified on this U/S (no U/S information needed on this requisition) Confirmed or suspected vanishing twin/co-twin demise identified on this U/S (provide U/S information for viable fetus)

U/S Date: \_\_\_\_\_ CRL: \_\_\_\_\_ cm mm BPD: \_\_\_\_\_ cm mm NT: \_\_\_\_\_ mm  
(YYYY/MM/DD) Crown-Rump Length Bi-Parietal Diameter Nuchal Translucency CRL 45.0-84.0 mm

**Sonographer's information:**

Operator Code: \_\_\_\_\_ Site: \_\_\_\_\_ Site phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**Ordering Professional:** \_\_\_\_\_ **Additional Report To:** \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signature : \_\_\_\_\_ Billing # \_\_\_\_\_ Provider Billing # \_\_\_\_\_

**For Blood Collection Centre Use Only**

Send 2 mL of serum to the laboratory indicated above (serum separator tube preferred). **Do not anticoagulate or freeze blood. Centrifuge. Send primary tube to laboratory if there is a gel barrier, otherwise aliquot.**

**Collection Centre:**  
 Specimen Date: \_\_\_\_\_ (YYYY/MM/DD) Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

*Lab Label*

