Requestors please note: All fields must be completed to get a correct result

National Screening Unit

Canterbury Health Laboratories

Antenatal Screening for Down Syndrome and Other Conditions

LabPLUS

FORM CC6533

BAR CODE

CHL, LabPLUS Use Only

COLLECTION

Date Taken:

Time Taken:

Collector:

Collection Location:

Instructions

☐ Serum Separator Tube (Gold Top)

SAMPLE HANDLING

Separate within 4 hours of collection. Store and ship serum at 4° C within 12 hours of collection. Otherwise freeze serum then send sample frozen.

SENDING LAB REFERENCE NUMBER

Family Name ..... First Names .....

NHI Number ..... Date of Birth ...../...../..... Patient DHB .....

REQUESTOR DETAILS (BLOCK LETTERS):

Name and Practice .....

Address .....

Contact Number: ..... Fax Number: .....

NZMC# or Midwifery Council# ..... Signature .....

TEST REQUEST

☐ First Trimester Combined Screening **[MSS1]** 9-13 weeks, 6 days

OR

☐ Second Trimester Screening **[MSS2]** 14-20 weeks

EXTRA REPORT

Name .....

Address .....

.....

.....

Multiple Pregnancy Yes ☐ No ☐ No. fetuses .....

LMP ...../...../..... EDD ...../...../.....

Dating Scan GA: CRL ..... mm on ...../...../.....

Ethnicity

Which ethnic group does the woman belong to?

Tick the boxes that apply

- ☐ NZ European
- ☐ Maori
- ☐ Samoan
- ☐ Cook Island Maori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (Specify)

Current Smoker Yes ☐ No ☐

Current Maternal Weight ..... kg

Height ..... cm

Threatened Miscarriage Yes ☐ No ☐

Type I Diabetes Yes ☐ No ☐

Previous Pregnancies

With Down Syndrome Yes ☐ No ☐

With Neural Tube Defect Yes ☐ No ☐

With other Chromosome Anomaly Yes ☐ No ☐

Please give details: .....

.....

.....

IVF Pregnancy Yes ☐ No ☐

If yes, please complete ALL fields below:

Assisted Reproduction Method:

.....

Transfer Date ...../...../.....

Egg Extraction Date ...../...../.....

OR

Age of Donor at Extraction .....

AND

Egg Donor Birth Date ...../...../.....

INFORMATION FOR WOMAN (To be completed by LMC)

Recommended timing for your blood test is between: ..... and .....

Recommended timing for your scan is between: ..... and .....

NT Scan will be done at: ..... (Radiology Practice)

Gestational Age at Sampling will determine which screen will be performed by Laboratory

For further screening information: LabPlus: www.labplus.co.nz; CHL: www.chl.co.nz; National Screening Unit: www.nsu.govt.nz

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