Canterbury Health Laboratories

Health New Zealand Te Whatu Ora | Lab PLUS

Antenatal Screening for Down Syndrome and Other Conditions

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

For NT Scans please complete a separate form from your Radiology Practice.

To order more forms:

LabPlus	email: newbornscreeningresources@adhb.govt.nz
Canterbury Health Labs	email: labinfo@cdhb.health.nz
	Ph: (03) 364 0484

Any questions phone:

LabPlus	0800 522 7587 (0800 LABPLUS)
Canterbury Health Labs	0800 843 522 (0800 THE LAB)

For further screening information:

LabPlus	www.labplus.co.nz
Canterbury Health Labs	www.chl.co.nz
Health NZ - Te Whatu Ora	www.tewhatuora.govt.nz

Antenatal Screening for Down Syndrome and Other Conditions

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*Family Name:_____ *First Name:_____

*NHI:_____ *Date of Birth:_____

Testing Lab Reference Number

REQUESTOR DETAILS (BLOCK LETTERS):

*Name and Practice: _____

Address: _____

*Contact Number:_____ Email: _____

NZMC/Midwifery Council #: _____ Signature: _____

COLLECTION

Date Taken:

Time Taken:

Collector:

Collection Location:

TEST REQUEST

□ First Trimester Combined Screening
(MSS1) 9-13 weeks 6 days

□ Second Trimester Screening
(MSS2) 14-20 weeks 6 days

EXTRA REPORT

Name:_____

Address:_____

_____

Email:_____

TUBE TYPE

□ Serum Separator Tube (Gold Top)

ETHNICITY

Tick all boxes that apply

□ NZ European
□ Māori
□ Samoan
□ Cook Island Maori
□ Tongan
□ Niuean
□ Chinese
□ Indian
□ Other: _____

SCREENING INFORMATION

*Multiple Pregnancy: Yes □ No □ # of Fetuses: _____

*LMP: _____

*EDD: _____

*Scan GA: _____ CRL: _____mm Date: _____

Current Smoker: Yes □ No □

*Current Maternal Weight: _____ kg

Height: _____ cm

Threatened Miscarriage: Yes □ No □

Insulin Dep. Diabetes: Yes □ No □

SAMPLE HANDLING

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

Date/Time Sample Spun

_____

Date/Time Aliquot Made

_____

PREVIOUS PREGNANCIES

With Down Syndrome: Yes □ No □

With Other Chromosomal Anomaly: Yes □ No □

Please give Details: _____

***IVF INFORMATION:** Yes □ No □ *If yes, please complete the fields below*

Assisted Reproduction Method: _____

Transfer date:_____

Egg Extraction Date:_____ **OR** Age at Extraction: _____

***DONOR INFORMATION (only fill if donor egg)**

Donor Date of Birth: _____ **OR** Donor Age at Extraction: _____

Sending Lab Reference Number

INFORMATION FOR WOMEN (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 the Laboratory

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

*** Compulsory information required for screening purposes**

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