

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.tewhatauora.govt.nz

 Antenatal Screening for Down Syndrome and Other Conditions		Health New Zealand Te Whatu Ora	
*Family Name: _____ *NHI: _____		*First Name: _____ *Date of Birth: _____	
REQUESTOR DETAILS (BLOCK LETTERS):			
*Name and Practice: _____ Address: _____		COLLECTION	
*Contact Number: _____ Email: _____		Date Taken: _____	
NZMC/Midwifery Council #: _____ Signature: _____		Time Taken: _____	
TEST REQUEST		EXTRA REPORT	
☐ First Trimester Combined Screening (MSS1) 9-13 weeks 6 days ☐ Second Trimester Screening (MSS2) 14-20 weeks 6 days		Name: _____ Address: _____ Email: _____	
ETHNICITY <i>Tick all boxes that apply</i>		SCREENING INFORMATION	
☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Maori ☐ Tongan ☐ Niuean ☐ Chinese ☐ Indian ☐ Other: _____		*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 ☐ <i>If yes, please complete the fields below</i> 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: _____			
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