






 Lab Use Only		 Canterbury Health Laboratories		 National Screening Unit		 Lab PLUS		Copy To: Address:  Ph:  Received Screening Lab	
Time/Date Taken:		Family Name		First Names		NHI Number		Date of Birth	
Location:		Patient DHB		LMC/DR LOCATION:		PHONE:		FAX:	
Collector:		NZMC# OR MIDWIFERY COUNCIL#		GP/LMC Ordering Tests		NAME IN BLOCK LETTERS		SIGNATURE	
ADDRESS		LMC/DR LOCATION:		PHONE:		FAX:		PLEASE INDICATE NO. OF SAMPLES COLLECTED: Sample to be collected: <input type="checkbox"/> Serum Separator Tube 7ml (Gold Top)	
<b>TO BE COMPLETED BY HEALTHCARE PROVIDER</b>					<b>LAB REQUEST</b>			<b>Info for collector/sending laboratory</b>	
Multiple Pregnancy Yes <input type="checkbox"/> No <input type="checkbox"/> No. foetuses ..... LMP ..... / ..... / ..... Scan Gestational Age: Wks ..... Days ..... on: ..... / ..... / ..... <small>Note: Only fill in if scanned but report unavailable</small>			<b>Which ethnic group does the woman belong to?</b> <small>Tick the boxes that apply</small>		<input type="checkbox"/> First Trimester Combined Screening [MSS1] 9-13 weeks, 6 days Please send copy of scan report OR NT Scan expected date: ..... / ..... / ..... NT Scan expected site: .....  <input type="checkbox"/> Second Trimester Maternal Serum [MSS2] 14-20 weeks <input type="checkbox"/> 1st Sample <input type="checkbox"/> Repeat Sample			Separate as soon as possible (must be within 4 hours of collection) Store and ship serum at 4°C. Send sample within 24 hours, otherwise freeze serum. <div style="border: 1px solid black; padding: 5px; text-align: center;">SENDING LAB REFERENCE NUMBER</div> Date/Time Separation: ..... By Lab: ..... Despatch Date: .....	
Fertility Date ..... / ..... / ..... Smoker Yes <input type="checkbox"/> No <input type="checkbox"/> Maternal weight kg on: ..... / ..... / ..... Height cm ..... Threatened Miscarriage Yes <input type="checkbox"/> No <input type="checkbox"/> Insulin Dependent Diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/> IVF Pregnancy Yes <input type="checkbox"/> No <input type="checkbox"/> Assisted Reproduction Method ..... Transfer Date ..... / ..... / ..... Egg Extraction Date ..... / ..... / ..... or Age of Donor at Extraction ..... Egg Donor Birth Date ..... / ..... / ..... Gestation at Sample Date ..... / ..... / .....			<b>Previous Pregnancies</b> With Down Syndrome? Yes <input type="checkbox"/> No <input type="checkbox"/> With Neural Tube Defect? Yes <input type="checkbox"/> No <input type="checkbox"/> With Other Chromosome Anomaly? Yes <input type="checkbox"/> No <input type="checkbox"/> Please give details: .....		<input type="checkbox"/> NZ European <input type="checkbox"/> Maori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other (Specify) .....			SENDING LAB REFERENCE NUMBER	

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LMC/DR LOCATION:		PHONE:		FAX:		NZMC# OR MIDWIFERY COUNCIL#		GP/LMC Ordering Tests	
NAME IN BLOCK LETTERS		SIGNATURE		LMC/DR LOCATION:		PHONE:		FAX:	
ADDRESS		LMC/DR LOCATION:		PHONE:		FAX:		PLEASE INDICATE NO. OF SAMPLES COLLECTED: Sample to be collected: <input type="checkbox"/> Serum Separator Tube 7ml (Gold Top)	
<b>TO BE COMPLETED BY HEALTHCARE PROVIDER</b>					<b>LAB REQUEST</b>			<b>RADIOLOGY SCAN REQUIRED</b>	
Multiple Pregnancy Yes <input type="checkbox"/> No <input type="checkbox"/> No. foetuses ..... LMP ..... / ..... / ..... Scan Gestational Age: Wks ..... Days ..... on: ..... / ..... / ..... <small>Note: Only fill in if scanned but report unavailable</small>			<b>Which ethnic group does the woman belong to?</b> <small>Tick the boxes that apply</small>		<input type="checkbox"/> First Trimester Combined Screening [MSS1] 9-13 weeks, 6 days Please send copy of scan report OR NT Scan expected date: ..... / ..... / ..... NT Scan expected site: .....  <input type="checkbox"/> Second Trimester Maternal Serum [MSS2] 14-20 weeks <input type="checkbox"/> 1st Sample <input type="checkbox"/> Repeat Sample			<input type="checkbox"/> NT Scan for First Trimester Combined Screening 11-13 weeks, 6 days [Gestational age, diagnosis of multiple pregnancy, type of twins, NT, CRL and/or biparietal diameter (if scanning is after 12 weeks)] Please fax scan report to: <b>For the following DHBs:</b> [NDBH, WDHB, CMDHB, ADHB, Waikato DHB, LDHB, BOPDHB] <b>Please fax to 09-307-4936</b>  <b>All other DHBs:</b> <b>please fax to 03-364-0750</b>	
Fertility Date ..... / ..... / ..... Smoker Yes <input type="checkbox"/> No <input type="checkbox"/> Maternal weight kg on: ..... / ..... / ..... Height cm ..... Threatened Miscarriage Yes <input type="checkbox"/> No <input type="checkbox"/> Insulin Dependent Diabetic? Yes <input type="checkbox"/> No <input type="checkbox"/> IVF Pregnancy Yes <input type="checkbox"/> No <input type="checkbox"/> Assisted Reproduction Method ..... Transfer Date ..... / ..... / ..... Egg Extraction Date ..... / ..... / ..... or Age of Donor at Extraction ..... Egg Donor Birth Date ..... / ..... / ..... Gestation at Sample Date ..... / ..... / .....			<b>Previous Pregnancies</b> With Down Syndrome? Yes <input type="checkbox"/> No <input type="checkbox"/> With Neural Tube Defect? Yes <input type="checkbox"/> No <input type="checkbox"/> With Other Chromosome Anomaly? Yes <input type="checkbox"/> No <input type="checkbox"/> Please give details: .....		<input type="checkbox"/> NZ European <input type="checkbox"/> Maori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Maori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other (Specify) .....			SENDING LAB REFERENCE NUMBER	

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