CANADIAN BLOOD SERVICES

PRENATAL SCREEN REQUEST

BC & YUKON CENTRE, 4750 OAK ST., VANCOUVER, BC V6H 2N9 • PHONE: (604) 707-3527 • FAX: (604) 874-6582

REQUEST:	☑ Prenatal	☐ Infertility	☐ Other _____	
BLOOD COLLECTED FROM:	☑ Mother	☐ Father	☐ Cord	☐ Other _____

PLEASE PRINT INFORMATION. **Specimens accompanied by an incomplete or illegible requisition will NOT be processed.**

SPECIMEN COLLECTED: _____ Facility: _____

Collected By: _____

MOTHER'S INFORMATION:

Last Name: _____ Given Names: _____

Birth Date: _____ PHN: _____

Previous (maiden) names: _____

EDC:

HOSPITAL FOR DELIVERY: Lions Gate Hospital

FATHER'S INFORMATION:

Last Name: _____ Given Names: _____

Birth Date: _____ PHN: _____

PLEASE NOTE: Specimens are **not** collected at Canadian Blood Services

MUST BE COMPLETED BY PHYSICIAN

Unexpected antibodies present?

☑ No ☐ Yes Antibody(s) _____

Reference No.: _____

Rh Immune Globulin given this pregnancy?

☑ No ☐ Yes Date: _____

Amniocentesis or CVS performed this pregnancy?

☑ No ☐ Yes Date: _____

PLACE SPECIMEN LABEL HERE

Ordering Physician:

Please send copy to Lions Gate Maternity Clinic

MSP Number:

Fax Number:

Fax Number: 604-985-6108