

This space for lab use only
Place LIS Label here

Pathology Services

Request for Placental Examination

This space for lab use only
Place AP label here

***Fields marked with an Asterisk are mandatory**

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION <i>(print or use addressograph)</i>	
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)	
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)	
Address:		*Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex	
Phone Number:	Fax No:	*PHIN:	
Critical Results Phone No.:		Specify if other province/ DND)	
*Physician Signature:		MRN:	
COPY REPORT TO <i>(if info missing, report may not be sent):</i>		Encounter Number:	
Last & Full First Name:	Fax No:	Patient Phone No.:	
Facility Name/ Address:	Phone No.:	Patient Address:	
Last & Full First Name:	Fax No:	Demographics verified: <input type="checkbox"/> Health Card <input type="checkbox"/> Armband <input type="checkbox"/> eChart/CR <input type="checkbox"/> Other	
Facility Name/ Address:	Phone No.:	*COLLECTION DATE and TIME: _____	

If microbiology testing is required, a specimen must be sent directly from the delivery room
Request to return placenta to family: No Yes

***INDICATE OPTION FOR SUBMISSION TO PATHOLOGY**

- Stillbirth** – pathology report will include microscopic examination Consent for release of remains (attached)
 Regular examination – State reason for submission: _____

Pathology report will include macroscopic description with tissue blocks retained for microscopic examination on request. Microscopy can be requested if required (even years later) by FAXing a consultation request to Pathology indicating the specific clinical question.

HSC FAX (204) 787-4942 SBH FAX (204) 235-3423 Westman FAX (204) 578-2819

- Immediate microscopy for clinical care** – State reason _____ and physician contact information (if not provided specimen will be processed per regular examination)

Additional Information:

MATERNAL HISTORY ***PLEASE COMPLETE ALL INFORMATION AND PRINT CLEARLY**

Age _____ BMI _____ LNMP _____ ECD _____
(dd/mmm/yyyy) (dd/mmm/yyyy)

G _____ P _____ Preterm _____ Alive _____ SB _____ NND _____ TA _____ SA _____ Multiples _____ Ectopic _____

Medical History:

***PRENATAL HISTORY**

PET / PIH	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Essential Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Smoker	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcohol Utilization	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Drug use	<input type="checkbox"/> No	<input type="checkbox"/> Yes
HSV	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Seizure disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Viral illness during pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Antepartum hemorrhage	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Additional Information:

***INFANT HISTORY**

Liveborn Stillborn Singleton Multiple (____ of ____) Date and time of birth: _____ (dd/mmm/yyyy) _____ (24 hours)

Birthweight: _____ **Sex:** Male Female Indeterminate

Apgars: 1 min _____ 5 min _____ 10 min _____

Presentation: Cephalic Breech Other (describe): _____

Membranes: SROM ARM Date and time: _____ Describe fluid: _____
(dd/mmm/yyyy) (24 hours)

Delivery: SVD C Section Forceps Vacuum

Additional Information: