For PDF Fillable Requisitions, the following applies:

1. The form shall be completed using a Digital Health assigned computer.
2. Absolutely no personal health information shall be electronically saved on a computer.
3. The completed form shall not be shared electronically. If you reasonably believe that e-mailing the information is the only available method of communication or the only way to send the information then you must adhere to the Privacy guideline titled "E-mailing Personal Health Information".
4. All forms must be completed in their entirety, e.g. if a staff member has only completed half of a form they cannot save their work and then come back to complete it at a later date.
5. Once the personal health information has been recorded onto the form, it is to be printed immediately, deleted (not saved) from the computer, and then stored securely inside the client (paper) health record or scanned into an electronic record.
6. Do not print unnecessary duplicate copies of the form.
7. Regular audits of the Digital Health assigned computer shall be undertaken to ensure that no personal health information is being duplicated and saved.

Pathology Services Request for Placental Examination

LAB USE ONLY
BARCODE

Fields marked with asterisk are mandatory and must be clearly legible

Submitting Provider Information		
*Last & Full First Name:		Billing Code:
*Inpatient Location/Facility Name/Address:		
Ph #:		
Critical Results Ph #:	Fax #:	
***Provider Signature:**	Ph #:	
Copy Report To *(if info missing, report may not be sent):*		
Last & Full First Name:	Ph #:	Fax #:
Facility Name/ Address:		
Last & Full First Name:	Ph #:	Fax #:
Facility Name/ Address:		

Patient Information *(print or use addressograph)*
*Last/First Name: (per Health Card)

* Date of Birth (dd/mm/yyyy)

*Sex: □ Female □ Male

*PHIN: Specify Province or DND if different
MRN:
Encounter#:

Demographics verified via:
❑ Health Card ❑ Armband ❑eChart/CR ❑ Other ❑Morgue

***COLLECTION DATE and TIME: _____**

If microbiology testing is required, a specimen must be sent directly from the delivery room

***INDICATE OPTION FOR SUBMISSION TO PATHOLOGY**

❑ **Stillbirth** – pathology report will include microscopic examination
Autopsy requested Yes ❑ No ❑ Sample sent for cytogenetics Yes ❑ No ❑ N/A ❑

❑ **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 _____ GA_____w_____d_____
(dd/mmm/yyyy) *(dd/mmm/yyyy)*

G _____ P _____ Preterm_____ Alive_____ SB _____ NND _____ TA _____ SA _____ Multiples _____ Ectopic _____

Medical History:

***PRENATAL HISTORY**

PET / PIH	❑ No	❑ Yes	**Additional Information:**
Essential Hypertension	❑ No	❑ Yes	
Anemia	❑ No	❑ Yes	
Smoker	❑ No	❑ Yes	
Alcohol Utilization	❑ No	❑ Yes	
Drug use	❑ No	❑ Yes	
HSV	❑ No	❑ Yes	
Seizure disorder	❑ No	❑ Yes	
Viral illness during pregnancy	❑ No	❑ Yes	
Antepartum hemorrhage	❑ No	❑ Yes	

***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: