

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.

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
Facility Name/ Address:	Phone No.:	<input type="checkbox"/> Other
		*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: \_\_\_\_\_

Birthweight: \_\_\_\_\_ Sex: ☐ Male ☐ Female ☐ Indeterminate (dd/mmm/yyyy) (24 hours)

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: