This space for lab use only
Place LIS Label here

Pathology Services
Request for Placental Examination

Fields marked with an Asterisk are mandatory

This space for lab use only
Place AP label here

ORDERING PROVIDER INFORMATION		PATIENT INFORMATION *(print or use addressograph)*
*Last & Full First Name:	Billing Code:	*Last/First Name: (per Health Card)
*Ordering Facility:		* Date of Birth (dd/mm/yyyy)
Address:		*Sex: □ Female □ Male □ Intersex
Phone Number:	Fax No:	*PHIN:
Critical Results Phone No.:		Specify if other province/ DND)
***Physician Signature:**		MRN:
COPY REPORT TO *(if info missing, report may not be sent):*		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: ❑ Health Card ❑ Armband ❑eChart/CR ❑ 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	❑ 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: