GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Laboratory ID: _____

NCC FORM 2A

EMR400890

CLINICAL INFORMATION FOR MISCARRIAGES, FETAL DEATH OR STILLBIRTH **(Regardless of Gestational Age)**	Hospital of Origin: _____ UMRN: _____ Surname: _____ Given Name: _____ DOB: _____ AFFIX HOSPITAL LABEL

CLINICAL INFORMATION TO BE COMPLETED BY CLINICAL STAFF

Present Pregnancy: ☐ FDIU ☐ TOP **Labour**: ☐ Spontaneous ☐ Induced

Estimated Gestation: _____ (weeks) **Gravida**: _____ **Parity**: _____

Date of Birth: _____/_____/_____

Antenatal history (including PROM, bleeding, hypertension, chorioamnionitis and a brief description of presentation etc):	
Maternal medical history:	**Known fetal abnormalities:**
Maternal investigation results (including NIPT, diagnostic genomics, imaging etc): *This should include information or copies of radiology and genetic reports where applicable.*	
Previous obstetric history:	
What specific questions would you, the requesting clinician, or next of kin like answered from this examination?	
Signature of Medical Practitioner:_____ **Name:**_____ **Date:**_____	