




PATIENT Last Name	Given Name (including middle initial)	Date of Birth	Sex	MANDATORY INFORMATION Requesting Doctor: _____ Provider Number: _____ Surname, Initials: _____ Address: _____ _____ Phone Number: _____ Signature: _____ Date: _____
PATIENT Address		Unit no.	Your Reference	
Consultant Obstetrician:		Livebirth (Y/N):		
Date of Delivery:		Birth Weight:		
Gravidity:	Parity:	Mode of Delivery:		
GESTATION (essential)				

<p><u>INDICATION FOR HISTOLOGICAL EXAMINATION</u> (please select all that apply)</p> <p><u>ANTEPARTUM CONDITIONS</u></p> <p>Maternal Indications</p> <p><input type="checkbox"/> Diabetes Mellitus - Pregestational or Poorly Controlled (please circle)</p> <p><input type="checkbox"/> Severe hypertensive disorder</p> <p><input type="checkbox"/> Maternal syphilis - treated/not treated/suspected (please circle)</p> <p><input type="checkbox"/> Other - eg Systemic autoimmune disease, Infection/Sepsis (placental swab for MC&S to be taken from the fetal side at time of delivery), Metastatic malignancy (please specify below)</p> <p>Obstetrical Indications</p> <p><input type="checkbox"/> Antenatal bleeding in the 2nd and 3rd trimester</p> <p>Fetal Indications</p> <p><input type="checkbox"/> Miscarriage or stillbirth / intrauterine fetal demise</p> <p><input type="checkbox"/> SGA (Birth weight <10th percentile)</p> <p><input type="checkbox"/> FGR (Drop in fetal growth of >50 percentile)</p> <p><input type="checkbox"/> Complications associated with multiple gestation (please specify below)</p> <p>Chorionicity and Amnioncity: _____</p> <p><input type="checkbox"/> Hydrops fetalis</p> <p><input type="checkbox"/> Severe fetal anomaly</p> <p><u>INTRAPARTUM / POSTPARTUM CONDITIONS</u></p> <p><input type="checkbox"/> Preterm delivery at <34+6 weeks</p> <p><input type="checkbox"/> Placental abruption</p> <p><input type="checkbox"/> Non-reassuring fetal heart testing requiring urgent or STAT delivery</p> <p><input type="checkbox"/> Retained placenta, rule out placenta accreta spectrum</p> <p><input type="checkbox"/> Postpartum haemorrhage</p> <p><input type="checkbox"/> Thick meconium, suspected meconium aspiration</p> <p><input type="checkbox"/> Compromised neonatal clinical condition at birth, defined as any of the following:</p> <p>* 5-min Apgar score <7 * Cord blood pH <7 * Resuscitation >10 min</p> <p>* Requiring ventilation/ICU admission</p> <p><input type="checkbox"/> Suspected neonatal sepsis (placental swab for MC&S to be taken from fetal side at time of delivery)</p> <p><input type="checkbox"/> Neonatal death</p> <p><u>PLACENTAL CONDITIONS</u></p> <p><input type="checkbox"/> History of placenta with pathology known to recur (eg Abruption, CHI, MPFD/MFI, VUE)</p> <p><input type="checkbox"/> Other placental abnormalities (please specify below)</p> <p><u>OTHER</u></p> <p><input type="checkbox"/> Please provide information in the box below</p>	<p>SOURCE / HOSPITAL</p> <p>_____</p> <p>WARD</p> <p>_____</p> <p>FIN. ELEC: PUB</p> <p>Copy Reports to:</p> <p>_____</p> <p>Fax No:</p> <p>_____</p> <p>(required to receive report copy)</p>
---	---

<p>ADDITIONAL CLINICAL HISTORY</p> <p><input type="checkbox"/> HIGH RISK (Blood borne infection)</p> <p><input type="checkbox"/> URGENT</p>	<p>COLLECTOR'S SIGNATURE</p> <p>I certify that the specimen was obtained from the mother named on this form. I established her identity by direct inquiry and/ or inspection of the wrist band. I labeled the samples immediately after collection. The mother has verified that her name and date of birth on all specimen containers are correct.</p> <p></p> <p>Date: ____ / ____ / ____ Time: _____</p>
<p>() Lab to send fresh placenta for T Pallidum PCR</p> <p>() Other Test Requested: _____</p>	<p> </p> <p>v 23/07/24</p>