



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)				

INDICATION FOR HISTOLOGICAL EXAMINATION (please select all that apply)

ANTEPARTUM CONDITIONS

Maternal Indications

Diabetes Mellitus - Pregestational or Poorly Controlled (please circle)

Severe hypertensive disorder

Other - eg Systemic autoimmune disease, Infection/Sepsis, Metastatic malignancy (please specify below)

Obstetrical Indications

Antenatal bleeding in the 2nd and 3rd trimester

Fetal Indications

Miscarriage or stillbirth / intrauterine fetal demise

SGA (Birth weight <10th percentile)

FGR (Drop in fetal growth of >50 percentile)

Complications associated with multiple gestation (please specify below)
Chorionicity and Amnionicity: _____

Hydrops fetalis

Severe fetal anomaly

INTRAPARTUM / POSTPARTUM CONDITIONS

Preterm delivery at <34+6 weeks

Placental abruption

Non-reassuring fetal heart testing requiring urgent or STAT delivery

Retained placenta, rule out placenta accreta spectrum

Postpartum haemorrhage

Thick meconium, suspected meconium aspiration

Compromised neonatal clinical condition at birth, defined as any of the following:
* 5-min Apgar score <7 * Cord blood pH <7 * Resuscitation >10 min
* Requiring ventilation/ICU admission

Suspected neonatal sepsis

Neonatal death

PLACENTAL CONDITIONS

History of placenta with pathology known to recur (eg Abruption, CHI, MPFD/MFI, VUE)

Other placental abnormalities (please specify below)

OTHER

Please provide information in the box below

SOURCE / HOSPITAL

WARD

FIN. ELEC: PUB

Copy Reports to:

Fax No:

(required to receive report copy)

ADDITIONAL CLINICAL HISTORY

HIGH RISK
(Blood borne infection)

URGENT

COLLECTOR'S SIGNATURE

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.

X

Date: ____ / ____ / ____ Time: _____

Other Test Requested: _____