GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Laboratory ID: _____ **NCC FORM 2A**

CLINICAL INFORMATION FOR MISCARRIAGES, FETAL DEATH OR STILLBIRTH (Regardless of Gestational Age)

Hospital of Origin: AFFIX HOSPITAL LABEL

UMRN: _____

Surname: _____

Given Name: _____

DOB: _____

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:**_____