GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Paediatric and Perinatal Pathology
Perth Children's Hospital
Hospital Avenue, Nedlands
Western Australia 6009

ENQUIRIES
(08) 6456 3296

PLACENTA EXAMINATION REQUEST

ULTRA No. (PathWest)

PATIENT Last Name	Given Name (including middle initial)	Date of Birth	Sex

PATIENT Address	Unit no.	Your Reference
use Patient label if available		

GESTATION (essential)

CLINICAL DETAILS

Consultant Obsetrician:	Livebirth (Y/N):
Date of Delivery:	Birth Weight:
Gravidity: Parity:	Mode of Delivery:

MANDATORY INFORMATION

Consultant:

Requesting Doctor:
Surname, Initials, Provider Number, Address, Phone and Fax Numbers. Fax number is required to receive a copy of the report.

Provider Number:

Surname, Initials

Address:

Phone No: _____

Fax No: _____

Location: _____

✗ _____ ___/___/___

Patients referred by GPs and private patients must complete the Medicare Assignment details below.

To comply with Privacy Act requirements, these patients must also provide consent for genomic test results to be entered into the iCM (see below).

☐ DO NOT SEND REPORTS TO MY HEALTH RECORD

Results to HDWA Clinical Information System (iCM)
See CIS informed Consent Information Sheet.

Patient Signature
I consent for my results to be stored in the iCM.

✗ _____

Patient Status at Time of Service or When Specimens Collected:

	YES	NO
1. A private patient in a private hospital or approved day hospital facility	☐	☐
2. A private patient in a recognised hospital	☐	☐
3. A public patient in a recognised hospital	☐	☐
4. An outpatient of a recognised hospital	☐	☐

INDICATION FOR EXAMINATION

- ☐ Stillbirth (antepartum or intrapartum)
- ☐ Miscarriage (<20/40 gestation)
- ☐ SGA (Birth weight < 10th percentile)
- ☐ FGR: Drop in fetal growth of >50 percentile
- ☐ Absent / reversed EDF on umbilical artery Dopplers
- ☐ Spontaneous preterm delivery or PPROM ≤34+6 weeks
- ☐ Iatrogenic preterm delivery ≤34+6 weeks
- ☐ Severe early onset (<34/40) pre-eclampsia requiring Iatrogenic delivery
- ☐ Abruption with retroplacental clot
- ☐ Fetal hydrops
- ☐ Suspected intrapartum fetal compromise: defined as: pH<7.21 or APGAR score <7 at 5 mins OR scalp lactate >4.8 mmol/L
- ☐ Maternal sepsis requiring adult ICU admission (placenta swab to be taken for microbiology at delivery)
- ☐ Fetal sepsis or clinical chorioamnionitis requiring ventilation / level 3 ICU (placental swab to be taken for microbiology at delivery)
- ☐ Complicated monochorionic twins with TTTS
  Twin A: weight _____ Cord clamps _____
  Twin B: weight _____ Cord clamps _____
- ☐ Placenta accreta spectrum
- ☐ Other (at obstetrician's discretion)

Copy Reports to:

Fax No: _____
(required to receive report copy)

Your doctor has recommended that you use PathWest. You are free to choose your own pathology provider. However, if your doctor has specified a particular pathologist on clinical grounds a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your doctor.

Specified APP: Yes / No

APP Name_____

Bill to:

Medicare Number:

_____

Medicare Assignment
(Section 20A Health Insurance Act 1973)
I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

Patient's Signature / Date

✗ _____ ___/___/___

Practitioner's Use Only
(Reason patient cannot sign)

ANY OTHER INFORMATION

- ☐ HIGH RISK (blood borne infection)
- ☐ URGENT

COLLECTOR'S SIGNATURE
I certify that the fetal specimen and accompanying maternal blood sample were 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

✗ Date: _____ / _____ / _____ Time: _____

PLACENTAS WITH THE FOLLOWING **ARE NOT** INDICATED FOR HISTOLOGICAL EXAMINATION UNLESS THERE ARE ADDITIONAL RELEVANT INDICATIONS:

- Maternal Group B streptococcus
- Maternal diabetes or other maternal disease with normal pregnancy outcome
- Known trisomy 13, 18, 21 / Turners
- Congenital anomaly
- Uncomplicated twin pregnancy
- Twins for assessment of chorionicity
- "Gritty" placenta
- Placenta praevia
- Post-partum haemorrhage
- Polyhydramnios
- History of previous molar pregnancy
- Cholestasis
- Hepatitis B/C, HIV
- Single umbilical artery
- Uncomplicated velamentous cord
- Placenta with accessory lobe.

If placentas are received from the "not indicated" list or without adequate clinical information, the placenta will be macroscopically examined only and histological blocks kept. If further information is forthcoming, histological examination can be requested by contacting PCH Anatomical Pathology at Perth Children's Hospital on 6456 3296 and providing appropriate clinical information to guide examination.

RCPA The Royal College of Pathologists of Australasia

NATA ACCREDITATION