



Laboratory Medicine

Placental Pathology Requisition



1V2460 1413 08 2016

Name: _____

HCN: _____

Date of Birth: _____

FOR LABORATORY USE ONLY

Specimen Number: _____ Site: _____

Date of Collection: DD/MONTH/YYYY

Legend: Indicate Status and Fixative in boxes below

Status: Routine (R), Urgent (U), Other Lab (O)

Fixative/solution: Dry (D), Formalin (F) Normal Saline (NS)

Nature/Source/Site of Specimen	Lab Use Only	Cold Ischemic /Collection Time	Status: See Above	Fixative /Solution: See Above	Time in Fixative	Nurse Initials See Below
1)	A					
2)	B					
3)	C					
4)	D					

Placenta Type

Singleton Twin; Clamp on _____

Other _____ Clamp on _____

Fetal Autopsy: If applicable

Requested Not requested

Delivery Outcome

Maternal Grava _____ Para _____

Gestational Age: _____ weeks

Delivery Method

NSVD

Cesarean delivery Indication _____

Other _____

Baby A:

Apgar: 1 min _____ 5min _____ 10min _____

Fetal weight: _____

Baby B: (If applicable):

Apgar: 1 min _____ 5min _____ 10min _____

Fetal weight: _____

Ancillary Testing: Check all that apply

Microbiologic culture (**Requires fresh tissue: Must be refrigerated at 4 +/-2 degrees if after hours**)

Cytogenetics (**Requires fresh tissue: Must be refrigerated at 4 +/-2 degrees if after hours**)

HISTORY Check all that apply.

- Maternal**
- Pre-eclampsia/eclampsia
 - Hypertension
 - Premature/ prolonged ROM
 - Oligiohydramnios
 - Peripartum fever/ Infection
 - Seizures
 - Diabetes
 - Lupus
 - Twinning Complication
 - Infection during pregnancy
 - Other _____

- Fetal**
- Transfer to NICU
 - Fetal Demise
 - NRFHT
 - Hydrops
 - Suspected Infection
 - IUGR
 - Macrosomia
 - Congenital anomalies
 - Vascular lesions
 - Meconium present
 - Multiple gestation _____
 - Other _____

- Placental**
- Gross lesion
 - _____
 - _____
 - Meconium staining
 - Chorioamnionitis
 - Abruption
 - Previa
 - Increta/percreta
 - Size discrepancy
 - Other _____

Nurse's Name	Nurse's Signature	Initials	Nurse's Name	Nurse's Signature	Initials

Physician/Surgeon Name: _____

Date: DD/MONTH/YYYY

Physician/Surgeon Signature: _____

Copy Report to: _____