Alberta Health Services

Calgary Laboratory Services

ANATOMIC PATHOLOGY PLACENTA REQUISITION

Scanning Label or Accession # *(lab only)*

Patient	PHN Expiry:		Date of Birth *(dd-Mon-yyyy)*	
	Legal Last Name	Legal First Name		Middle Name
	Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
	Address	City/Town	Prov	Postal Code

Provider (s)	Authorizing Provider Name *(last, first, middle)*		Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
	Address	Phone	Address	Address
	CC Provider ID / CC Submitter ID	Legacy ID	Phone	Phone
	Clinic Name		Clinic Name	Clinic Name

Collection	Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID
	Date of Delivery *(dd-Mon-yyyy)*			

INFORMATION TO BE COMPLETED IN THE CASE ROOM

Gestation _____ weeks	Sex ☐ Male ☐ Female ☐ Unsure	Membrane Ruptured >24 hours ☐ No ☐ Yes Specify: _____	Meconium Stained Liquor ☐ No ☐ Yes
☐ Livebirth ☐ Stillbirth	Weight _____ GMS	Abruptio Placenta ☐ No ☐ Yes	Placenta Previa ☐ No ☐ Yes
Delivery ☐ Vertex ☐ Breech ☐ C/S	APGAR ____ (1 min) ____ (5 min) ____ (10 min)	Prolonged Labour ☐ No ☐ Yes	Fetal Distress ☐ No ☐ Yes

Any Maternal Illness: Gravida _____ Para _____ Infectious patient? ☐ No ☐ Yes: _____

REMARKS