

Anatomic Pathology Placenta Requisition

Scanning Label or Accession # *(lab only)*

Patient

Order Date <i>(dd-Mon-yyyy)</i>			
PHN	Expiry: _____	Date of Birth <i>(dd-Mon-yyyy)</i>	
Legal Last Name		Legal First Name	Middle Name
Alternate Identifier	Preferred Name	<input type="checkbox"/> Male <input type="checkbox"/> Non-binary	<input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose
Address		City/Town	Prov Postal Code

Provider(s)

Authorizing Provider <i>(last, first, middle name)</i>		Address	
Clinic Name	Phone	CC Provider ID	CC Submitter ID
Copy to	Address	Phone	Clinic Name
Copy to	Address	Phone	Clinic Name

Collection

Date <i>(dd-Mon-yyyy)</i>	Time <i>(24 hr)</i>	Location	Collector ID
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Information to be Completed in the Case Room

Gestation _____ weeks	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Unsure
Membrane Ruptured greater than 24 hours	<input type="checkbox"/> No	<input type="checkbox"/> Yes ▼	Meconium Stained Liquor	<input type="checkbox"/> No <input type="checkbox"/> Yes
Specify _____				
<input type="checkbox"/> Livebirth	<input type="checkbox"/> Stillbirth	Weight _____ grams	Abruptio Placenta	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> No	<input type="checkbox"/> Yes		
<input type="checkbox"/> Vertex	<input type="checkbox"/> Breech	<input type="checkbox"/> C/S	APGAR _____ (1 min)	_____ (5 min)
_____ (10 min)				
Prolonged Labour	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Fetal Distress	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gravida	Para	Infectious patient?	<input type="checkbox"/> No <input type="checkbox"/> Yes ►	_____

Any Maternal Illness

Remarks