



(918)-417-6400/(918)-416-0506

PLACENTA PATHOLOGY REQUISITION

PLACE PATIENT LABELS HERE

To be completed and accompany placenta to the Pathology lab

GENERAL INFORMATION		
MOTHER'S NAME	MOTHER'S DOB	EGA
BIRTH WEIGHT	APGAR SCORE (1 / 5 MIN.)	LENGTH OF CORD REMOVED 3 - 6 in (7.5 - 15 cm) removed for routine drug sample _____ in / _____ cm total removed for drug sample + other
CHECK ONE <input type="checkbox"/> Cesarean Section <input type="checkbox"/> Vaginal Delivery	DELIVERY DATE	DELIVERY TIME
PROLONGED RUPTURE OF MEMBRANES <input type="checkbox"/> < 12 hours <input type="checkbox"/> 12 - 24 hours <input type="checkbox"/> > 24 hours		

Reasons for Pathology Review (Check all that apply):

MATERNAL INFORMATION
<input type="checkbox"/> Preeclampsia / Eclampsia <input type="checkbox"/> Seizures <input type="checkbox"/> Postmaturity (> 42 weeks) <input type="checkbox"/> Hypertension <input type="checkbox"/> Severe Anemia <input type="checkbox"/> Severe Oligohydramnios <input type="checkbox"/> Diabetes <input type="checkbox"/> Collagen-Vascular Disease <input type="checkbox"/> Unexplained Vaginal Bleeding <input type="checkbox"/> Infection <input type="checkbox"/> GBST <input type="checkbox"/> Abruptio / Previa <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Fever <input type="checkbox"/> Prematurity (< 36 weeks) <input type="checkbox"/> History of substance abuse: <input type="checkbox"/> Prior Pregnancy Complications (e.g. Stillbirth, Neonatal Death, Repeated Spontaneous Abortion, IUGR, Prematurity) _____ <input type="checkbox"/> Other Complications: _____

FETAL / NEONATAL INFORMATION
<input type="checkbox"/> Stillbirth / Perinatal Death <input type="checkbox"/> Multiple Gestation <input type="checkbox"/> Congenital Anomaly <input type="checkbox"/> Infection / Sepsis <input type="checkbox"/> Fetal / Perinatal Distress <input type="checkbox"/> Seizures <input type="checkbox"/> NICU Admit <input type="checkbox"/> Hydrops Fetalis <input type="checkbox"/> IUGR <input type="checkbox"/> Other : _____

PLACENTAL ABNORMALITIES
<input type="checkbox"/> Meconium Staining of Membranes <input type="checkbox"/> Cord Abnormalities <input type="checkbox"/> Placental Lesion <input type="checkbox"/> Membrane Anomaly <input type="checkbox"/> Abnormal Size or Shape <input type="checkbox"/> Other Abnormalities: _____

TESTING REQUESTED

PATHOLOGY

<input type="checkbox"/> Tissue Exam: Gross and Microscopic Analysis <i>If no special studies requested below, send tissue in formalin</i>
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SPECIAL STUDIES

<input type="checkbox"/> Routine Cultures: Bacterial and Viral Cultures <input type="checkbox"/> Cytogenetics <input type="checkbox"/> Other : _____ <i>If special studies are requested, send tissue fresh (no formalin)</i>

ORDERING PHYSICIAN: _____ SIGNATURE: _____