

UR number \_\_\_\_\_

Surname \_\_\_\_\_

Given name/s \_\_\_\_\_

Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

(Affix maternal label)

## Clinical Information Form: Before commencement of Placental pathology

**Please fill this form and include a signed placenta pathology request form:**

Consultant/Team:
Indication for request:
Gestation:

### Relevant clinical history

	Please State Yes (Y) or No (N)
Perinatal death	
Post-mortem	
Surface/subchorionic swabs taken for cultures	
Karyotype performed	
Preterm infant (<34/40 weeks)	
Prolonged rupture of membranes (>24hrs)	
Suspected maternal/fetal bacterial or viral infection	
Fetal growth restriction (FGR) or SGA	
Pre-eclampsia	
Essential hypertension	
Diabetes	
Placenta praevia	
Multiple pregnancy	
<i>Type of multiple pregnancy</i>	
Unexplained bleeding/clinical abruption	
Fetal anomaly	

### Other relevant clinical history

### Relevant factors at time of labour/birth

Signature: \_\_\_\_\_

Designation: \_\_\_\_\_

Date:    /    /

Print name: \_\_\_\_\_