

Date: _____

**DEPARTMENT OF PATHOLOGY
REQUISITION**

Service notified? Yes No

Fax requisition to (314) 617-2786

Note: Please send the original of this completed form with the placenta

PATIENT NAME (MOTHER'S NAME) (LAST, FIRST, MI):

MEDICAL RECORD NUMBER: REFERRING ENTITY:

CONTACT PHYSICIAN: PAGER NUMBER: OFFICE PHONE NUMBER: FETUS AND PLACENTA (completed autopsy permit required) PLACENTA ONLY UTERUS

CATEGORY – check all that apply		CATEGORY – check all that apply	
Intrauterine fetal demise		At discretion of physician	
Postnatal delivery room death		Congenital infection	
Fetal congenital anomaly(ies)		Placental abnormality noted pre- or post-delivery (including possible trophoblastic disease, accreta, etc.)	
Intrauterine growth restriction (pre- or postnatal EFW < 10%ile)		Preterm delivery < 32 weeks	
Multiple pregnancy		NICU admits	
Depressed infant (5 minute APGAR < 3, pH ≤ 7.00)			

GESTATIONAL AGE AT DELIVERY:

SPECIFIC QUESTIONS TO BE ADDRESSED:

phone (314) 617-2800 • fax (314) 617-2786