Case Number

ALLINA HEALTH LABORATORY
LABLINK SUPPLEMENTAL FORM; HISTOPATHOLOGY - PLACENTA
2800 10th Ave. S., Ste 2000, Minneapolis, MN 55407
Phone: 612-863-4678 • Fax: 612-863-4067
HOSPITAL PATHOLOGY ASSOCIATES, P.A.

DO NOT ORDER MANUALLY **- Order resides in Beaker**

Sending Location: ____________________________________

Enter the patient name, date of birth and MRN in this space, or affix a patient label containing this information here:

This completed form must accompany any placenta specimens submitted to Allina Health Laboratory via a LabLink/Atlas order (interfaced or portal).

Indications for examination by pathology *(Check all that apply)*

FETAL/NEONATAL INDICATIONS:

- ☐ Prematurity
- ☐ Post-dates
- ☐ Multiple gestation
  Selective reduction?
  ☐ Yes: # reduced ____ ☐ No
- ☐ IUGR (Intrauterine growth restriction)
- ☐ PROM (specify)__________________________
- ☐ Oligohydramnios/polyhydramnios
- ☐ Stillborn/perinatal demise
- ☐ Congenital abnormalities (specify):
  ____
- ☐ Fetal/Neonatal Infection
- ☐ Fetal or neonatal stress (including low APGARS)
- ☐ Abnormal amniocentesis or Ultrasound
  Specify: ___________________________
- ☐ Other (specify):_________________________

MATERNAL INDICATIONS:

- ☐ Maternal diabetes (Gestational or non-gestational)
- ☐ Maternal hypertension
- ☐ Pre-eclampsia or eclampsia (Circle one)
- ☐ Maternal substance use
- ☐ Poor obstetric history
- ☐ Maternal fever
- ☐ Maternal infection during pregnancy
- ☐ Maternal collagen vascular disease (specify)
  ____
- ☐ Maternal hypercoagulable disorder (specify)
  ____
- ☐ Maternal thrombophilia (specify)
  ____
- ☐ Maternal abdominal/pelvic trauma
- ☐ Other (specify) ________________________

PLACENTAL INDICATIONS:

- ☐ Abnormal placental appearance (specify)
  ____
- ☐ Abruption
- ☐ Suspected abruption
- ☐ Thick meconium
- ☐ Abnormal umbilical cord (specify)
  ____
- ☐ Abnormal cord insertion
  (Marginal or velamentous)
- ☐ Abnormal membrane insertion
  (Circumvallate or circummarginate)
- ☐ Other (Specify) ________________________

INFECTIOUS SPECIMENS

(eg. Maternal HIV or HCV)

☐ Yes ☐ No

CYTOGENETICS STUDIES *(required)*

- ☐ Not requested
- ☐ Requested, sample sent
- ☐ Requested, sample *not* sent (Pathology to send sample)

CLINICAL INFORMATION *(required)*

Date of delivery:_________________
Time of delivery: _________________
Type of Delivery: ☐ Vaginal ☐ C-Section
Live Born: ☐ Yes ☐ No
Gestational Age: ______________weeks
Birth Weight of Infant(s): ___________ grams
Sex of Infant (s): ☐ Male ☐ Female
☐ Male ☐ Female

MATERNAL HISTORY *(required)*

Maternal Parity:

G ____ P ____

-or-

G ___ T ___ P ____ A ____ L ___

Diabetes: ☐ Yes ☐ No
Hypertension: ☐ Yes ☐ No
Eclampsia: ☐ Yes ☐ No
Smoking: ☐ Yes ☐ No

Other (specify):___________________________

AUTOPSY INFORMATION (*required*)

- ☐ Not applicable
- ☐ Will be performed
  Permit signed? ☐ Yes ☐ No
- ☐ Will ***NOT*** be performed
- ☐ Undecided

 Number of Containers ____________________