



## PLACENTA EXAMINATION REQUEST FORM

Patient Name \_\_\_\_\_

Obstetrician \_\_\_\_\_

Pediatrician \_\_\_\_\_

**Prenatal History:**

Race \_\_\_\_\_ Gravidity \_\_\_\_\_ Parity \_\_\_\_\_ Abortus \_\_\_\_\_

Stillborn \_\_\_\_\_ Living \_\_\_\_\_

EDC \_\_\_/\_\_\_/\_\_\_ Date Delivered \_\_\_/\_\_\_/\_\_\_ Maternal Weight \_\_\_/\_\_\_ Weeks of Gestation: \_\_\_\_\_  
( \_\_\_ lbs \_\_\_ Kg) Usual/At delivery

**History During This Pregnancy**

Toxemia \_\_\_Yes\_\_\_No Rubella \_\_\_Yes\_\_\_No If yes, Trimester\_\_\_

Pre-eclampsia \_\_\_Yes\_\_\_No Alcohol/Drug Abuse \_\_\_Yes\_\_\_No

Smoking \_\_\_Yes\_\_\_No If Yes, Cigarettes/Day\_\_\_ Influenza\_\_\_Yes\_\_\_No If Yes, Trimester\_\_\_

Diabetes\_\_\_Yes\_\_\_No Prior IUGR or fetal distress \_\_\_Yes\_\_\_No

Anemia \_\_\_Yes\_\_\_No Seizure Disorder \_\_\_Yes\_\_\_No

Herpes \_\_\_Yes\_\_\_No Other/Drugs \_\_\_\_\_

Delivery: \_\_\_Vaginal\_\_\_C-Section Placental Weight: \_\_\_\_\_grams (unfixed weight)

Infant: APGAR: \_\_\_1min\_\_\_5min Sex: \_\_\_M\_\_\_F Liveborn: \_\_\_\_\_Stillborn\_\_\_\_\_ Birthweight\_\_\_\_\_(grams)

Fetal Distress: \_\_\_Yes\_\_\_No Other\_\_\_\_\_ Amniotic Fluid:  
\_\_\_Normal\_\_\_Excessive\_\_\_Reduced

Amniotic Fluid Color\_\_\_\_\_Other\_\_\_\_\_

Umbilical Cord: Around fetal part? \_\_\_Yes\_\_\_No Cord sent for drug testing? \_\_\_Yes\_\_\_No If yes, approx.length sent:  
\_\_\_\_\_cm

Membranes Ruptured: \_\_\_In Hospital\_\_\_prior to admission

Additional Clinical Information: \_\_\_\_\_

Completed By: \_\_\_\_\_RN

This form **MUST** accompany all placenta exam requests