



EMBRYOPATHOLOGY CONSULTATION REQUEST

FOR CASES 19 WEEKS 6 DAYS GESTATIONAL AGE OR LESS

The process will be **delayed** if this form is not completed.
 (ALL INFORMATION IS REQUIRED)

EP Specimen Label

SURNAME _____ GIVEN NAMES _____

DATE OF BIRTH _____

MSP NUMBER _____

HOSPITAL/FACILITY _____

REQUESTING PHYSICIAN _____

COPIES TO _____

CONSENT:

By signing this requisition I, _____ (Patient's name), hereby:

- Consent** to the examination of these products of conception.
- DO NOT consent** to the examination of these products of conception.

Patient's signature: _____ Date: _____

Witness' signature: _____ Date: _____

STATEMENT BY INTERPRETER COMPLETE ONLY IF A PROFESSIONAL INTERPRETER IS USED TO OBTAIN CONSENT. I have translated the above information to: the patient the parent the legal guardian or representative and I have interpreted their responses to the health care professional.

INTERPRETER NAME (PRINT): _____ SIGNATURE: _____ DATE: _____

CLINICAL INFORMATION: DECLARATION OF GESTATIONAL AGE (AS DETERMINED BY CLINICIAN): _____

GRAVIDA: _____ PARA: _____ DATE OF DELIVERY OR SPECIMEN COLLECTION: _____

RELEVANT PREGNANCY AND MEDICAL HISTORY (PLEASE INCLUDE RELEVANT REPORTS, e.g. PRE-NATAL SCREENING, U/S FINDINGS, MEDICAL GENETICS CONSULTATION, ETC.):

SPECIMEN TYPE: SPONTANEOUS LOSS MISOPROSTOL INDUCTION D&E/D&C

DISPOSITION: C&W REFERRING CENTRE - Name: _____

REQUESTING PHYSICIAN:

NAME (PRINT): _____ SIGNATURE: _____ MSP: _____

FOR EP LAB USE ONLY

DATE RECEIVED: _____ DATE PROCESSED: _____ PATH: _____ TECH: _____

FINDINGS: PLAC: _____ DEC: _____ OTHER: _____

CG: _____ FROZEN: _____ PHOTOS: _____ MISC: _____

SJ: _____ HISTO: _____