BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
An agency of the Provincial Health Services Authority

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:**_____

White – Health Records Canary – Pathology Pink – Patient / Parent / Guardian