VPAS

Victorian Perinatal Autopsy Service

UR number
Surname
Given name/s
Date of birth Gender
(Affix maternal label)

Clinical Information Form:
Before commencement of Placental pathology

Please fill this form and include a signed placenta pathology request form:

Consultant/Team:
Indication for request:
Gestation:

Relevant clinical History

	Please State Yes (Y) or No (N)
Perinatal Death	
Post-mortem	
Surface/subchorionic swabs taken for cultures	
Karyotype performed	
Preterm infant (<34/40 weeks)	
Prolonged rupture of membranes (>24hrs)	
Suspected maternal/fetal bacterial or viral infection	
Fetal growth restriction (FGR) or SGA	
Pre-eclampsia	
Essential hypertension	
Diabetes	
Placenta praevia	
Multiple pregnancy	
Type of multiple pregnancy	
Unexplained bleeding/clinical abruption	
Fetal anomaly	
Other relevant clinical history	
Relevant factors at time of labour/birth	

Signature: **Print name:**
Designation:
Date: / /