

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

MR#: \_\_\_\_\_ DOB: \_\_\_\_\_

**REQUISITION FOR  
PERINATAL CENTER LABORATORY**

Requesting Physician: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Report to be sent to above physician  YES  NO

**PATIENT HISTORY**

Gravida: \_\_\_\_\_ Para: \_\_\_\_\_

EDC: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Weeks of gestation: \_\_\_\_\_

- Complications:**
- Placenta previa
  - Premature rupture of membranes
  - Preterm labor
  - Suspected abruptio placenta
  - IUGR
  - Hypertension, chronic
  - Preeclampsia/eclampsia
  - Fetal anomalies; specify \_\_\_\_\_
  - Maternal medical condition; specify \_\_\_\_\_
  - Other; specify \_\_\_\_\_

**TESTS REQUESTED:**

L/S  PG

**FLUID SOURCE:**  Transabdominal  
 Transvaginal

**Indications:**  <34 weeks gestation

**OR**

>34 weeks gestation and one of the following conditions:

- Diabetes Class \_\_\_\_\_
- Uncertain dates
- No prenatal care
- Fetal anomaly
- Chorioamnionitis
- Polyhydramnios
- Other; please specify \_\_\_\_\_

**AFLM (Amniostat)** (L/S & PG will not be run concurrently with AFLM unless a valid specific indication is noted.)

**Indications:** > 34 weeks gestation and none of the above conditions

**OR**

Other; Please specify \_\_\_\_\_

**ffN (Fetal Fibronectin)**