



## Request to the STIS

**Sender** (our centre answers healthcare professionals):

**Date of request:**

Name :

Street :

Postal code/City :

Phone :

Fax :

**Patient** (our centre accepts anonymous requests with initials and year of birth):

Last name :

First name :

Birth date :

**Pregnancy:**

Date of last menstrual period :

Gestational week (ultrasound) :

**Gravida :**

**Para :**

**Previous pregnancies:**  Elective abortion .....  Spontaneous abortion .....

**Current pregnancy :**

Spontaneous  IVF  ICSI  Ovarian stimulation  Other

Desired  Unexpected and accepted  Ambivalent  Not desired (elective abortion planned)

**Medication to which the patient was exposed**

Medication	Daily dose	Route of administration	Administration from*	to**	Indication
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. Folic acid <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> ?	_____	_____	_____	_____	_____

\* Date or duration (number of days / months / years) \*\* Date, duration or if treatment is pursued : ONGOING

Comments :

**Other risk factors for this pregnancy :**

- Alcohol consumption  yes  no  ? Quantity .....
- Tobacco use  yes  no  ? Number of cigarettes/day .....
- Illicit drug use  yes  no  ? Substances, frequency \_\_\_\_\_
- Hypertension  yes  no  ?
- Diabetes  yes  no  ?
- Obesity  yes  no  ? Weight..... Height ..... (preconceptional)
- History of congenital anomaly  yes  no  ?
- Risk related to psycho-social context  yes  no  ?

Other :



**Examinations/tests**

Pregnancy test :	Date	2	0	Result	
Ultrasound :	Date	2	0	Result	
Karyotype :	Date	2	0	Result	

Other :

**Chemicals :**

Professional activity percentage :                      Duration of exposure :  
Ventilation of premises :  yes  no  
Protection : gloves, glasses, coat, ventilation hood  
Symptoms (ENT, headache) :

**Breastfeeding :**

Child age :              Gestational age at birth :              Child's weight :              Breastfeeding :  
 complete  partial

**Gynaecologist who will follow this pregnancy:**

Name:

Address :

Phone :