



E-mail : stis@chuv.ch

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 :

