Placenta Examination, Histological Investigation and Disposal of Placenta following Birth Guideline

Guideline information

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Summary of document:
This guideline provides research based guidance for staff on the clinical examination of placenta, the appropriate referral of placenta for histopathology examination and the safe disposal of the placenta.

Scope:
The guideline is relevant to midwives and obstetricians who provide care for women in all clinical settings and at home.

This guideline makes recommendations for women and birthing people who are pregnant. For simplicity of language the guideline uses the term women/person throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

To be read in conjunction with:
149 - Hand Hygiene Policy – opens in new tab

Patient information:
Include links to Patient Information Library

Owning group:
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2.0 – Updated

Keywords
Placenta, Membranes, Histopathogy, Universal disposal, Non-Universal disposal

Key points:
Guidance for the clinical examination of placenta, appropriate referral of placenta for histopathology examination and the safe disposal of the placenta.

Contents

Scope
The guideline is relevant to midwifery/ Nursing and medical staff who provide care for women in all clinical settings and at home.

Aim
The aim of this document is to:
- To standardise a systematic approach for examining the placenta and membranes after birth
- Provide evidence based guidance to identify which placentas need to be sent for histology following delivery, promoting uniformity of approach and ensuring standards are met.
- Provide guidance and information when women chose to take their placenta home
- Ensure that the main underpinning themes are risk management and infection control

Objectives
The aim of this document will be achieved by the following objectives:
- Provide consistent advice and guidance on the examination of the placenta following birth
- Provide clear information of: criteria for referral to histopathology, process for sending placenta to appropriate Histopathology department.
- Provide clarity as to safe Disposal of placenta, both Universal and Non-Universal disposal.

The Placenta
A fresh, term, healthy placenta is approximately 15 – 20 cm in diameter and 2.0 to 2.5 cm thick. It generally weighs approximately 500-600gms (1/6 of the baby's birth weight). However, the measurements can vary considerably depending on a number of variables including ethnicity, pathophysiology, and baby weight.

The maternal surface of the placenta should be dark maroon in colour and should consist of around 15-20 cotyledons, which are divided by septa.

The fetal surface of the placenta should be shiny, grey, and translucent so that the colour of the underlying maroon villous tissue may be seen.

Insignificant changes can occur such as infarctions due to the depositing of fibrin, and the surface can appear gritty due to lime salt deposits.

Umbilical Cord
At term, the typical umbilical cord is 55 to 60 cm in length, with a diameter of 2.0 to 2.5 cm, and is twisted spirally in order to protect the vessels. Cord vessels are suspended in Wharton's jelly and covered by the amnion. The normal cord contains two arteries and one vein and is usually inserted in the centre of the fetal surface with blood vessels branching outwards.

Membranes
The membranes consist of two layers, the amnion, and the chorion.

Considerations in Multiple Pregnancy

The placenta and membranes for multiple births are more complex as there are a variety of possible combinations of placenta and membranes .Visually, the surfaces and cord are as described above for singletons.

When checking membranes it is helpful to look at the early ultrasound report to see what type of twins were confirmed:

- Monochorionic,Monoamniotic (MCMA) twins
  Rare occurance, one placenta, one amnion and one chorion and two cords

- Monochorionic, Diamniotic (MCDA)twins
  One placenta, one chorion, two amnion and two cords

- Dichorionic, diamniotic (DCDA) twins always have two separate placental units, each with own chorion and amnion,(i.e. two chorion and two amnion in total) They may, however, be side by side, and appear to be joined at first glance

Examination of Placenta

Ensure the woman is comfortable following birth, monitor the blood loss and check the uterus is well contracted. The examination of the placenta and membranes should take place as soon as possible following this to ensure that they are complete and that no further actions are required before the woman is discharged or transferred to the ward.

- Explain the procedure to the parents and ask if they want to observe.

- Ensure that there is adequate lighting to check the placenta. If the lighting in the birth room is dim, it is advised that the placenta is examined in an alternative location where there is adequate lighting. In the home the midwife should ask if an alternative room can be used with good lighting.

- Prepare a flat surface with protection to avoid blood spillage.

- Prepare syringe and needle if cord samples are required.

- Wash hands; wear an apron and gloves.

- Lay out the placenta with the fetal surface uppermost – noting shape, size, colour and smell.

- Examine the cord, noting the length, insertion point and presence of true knots or thrombi.

- Inspect the umbilical cord vessels at the cut end at the furthest point from the placenta as the arteries can be fused around the insertion site making it difficult to differentiate them.

- Count the vessels in the cut end of the cord; and document if there is absence of one of the arteries i.e. two vessel cord.

- Observe the fetal side for irregularities such as succenturiate lobes, missing cotyledons, fatty deposits, or infarctions.

- By lifting the cord and holding the placenta up, you can then observe the membranes and inspect for completeness. There should be a single hole present where the baby has passed through the membranes.

- Separate the amnion from the chorion by pulling the amnion back over the base of the umbilical cord to ensure both membranes are present and appear complete not ragged.

- Examine the cotyledons, ensuring all are present, noting the size and any areas of infarction, blood clots or calcification. Retain the clots to make an accurate assessment of blood loss. The lobes of a complete placenta fit neatly together without any gaps with the edges forming a uniform circle. Broken fragments of cotyledon should be carefully replaced before making an accurate assessment, e.g., succenturiate lobes, missing cotyledons, fatty deposits, or infarctions.

- Take swab or samples if indicated.

- If the placenta is examined by a student midwife, the supervising midwife must also examine the placenta to ensure completeness and countersigned the records to confirm this.

- Where there is suspicion that the placenta and/or membranes are incomplete, keep for further inspection and referred to the senior on-call obstetrician and inform senior/midwife coordinator.

- Where there is suspicion/evidence of APH due to vasa praevia, photos should be taken and stored in the woman's medical notes

- Clean away equipment.

Discussion and Documentation of Findings

- Discuss/ explain findings with the woman.

- It is important to inform the woman if there are concerns about the completeness of the placenta. She should be advised to be observant for an increase in blood loss/ passing clots/ signs of infection and advised to seek professional advice from a midwife or doctor as soon as possible

- Inform the senior on call obstetrician and senior midwife

- Clearly document in the maternal health record and postnatal record to alert other health care professionals attending the woman in the postnatal period.

- At a homebirth or in the Midwifery Led Care Unit, If the placenta is thought to be incomplete the woman may need to be transferred into the consultant unit for evacuation of retained products of conception

- If membranes appears ragged and bleeding is normal , uterus well contracted and post birth observations within normal limits advise woman to be observant for an increase in blood loss/ passing clots/ signs of infection and advised to seek professional advice from a midwife or doctor as soon as possible.

Investigations of the Placenta

Placentas should be swabbed on both fetal and maternal sides for the following reasons:

- Maternal intravenous antibiotics in labour for confirmed or suspected sepsis.
- Offensive smelling liquor.
- Suspected Chorioamnionitis.
- Baby born in unexpected poor condition (not associated with IUGR or
- known pathology).

Role of Histopathology

There are occasions where the placenta may need to be sent for histological investigation. This may be due to a poor outcome or to aid in treatment for the neonate

Histopathological examination of the placenta following a pregnancy affected by medical complications, pregnancy loss or neonatal death may provide an explanation of the pregnancy complications, pregnancy loss or neonatal death and may also provide information relevant to the management of the current infant and/or subsequent pregnancies and medico legal litigation. (RCOP.2022)

Indications for sending a Placenta for Histological Examination

- Severe fetal growth restriction (<3rd centile) And /Or abnormal umbilical artery Dopplers (absent or reversed end diastolic flow)
- Preterm birth (less than 32+0 weeks' gestation
- Miscarriage (14+0–23+6 completed weeks' gestation) (not including termination of Pregnancy)
- Twins pregnancy with complications of TTTS TAPS or discordant growth
- Morbidly adherent placenta with incomplete removal or major obstetric haemorrhage during removal of the placenta
- A baby with low Apgars at 5 minutes requiring resuscitation / abnormal blood gases defined as: pH <7.05 or Base Excess ≥–12
- Severe maternal sepsis requiring adult intensive care admission and/or fetal sepsis requiring ventilation or SCBU admission (following swab taken from the placenta for microbiology at delivery)
- Congenital abnormality
- Termination of pregnancy for Fetal abnormality -only if requested by Fetal Medicine
- Fetal hydrops
- Early-onset (<32 weeks) severe pre-eclampsia requiring iatrogenic delivery
- Stillbirth / Neonatal death:
    - If the parents **consent to a post mortem** examination the placenta should be send for full investigation with the baby to University Hospital Wales (UHW)
    - If the parents have **declined** post mortem on the baby, the placenta should be sent for specialist perinatal pathology (UHW). Label the PM request form 'placenta only'

Please note that placenta's should be retained from a home or MLU birth for any of the above indications.

Not indications for Histological Examination

Do not refer for the following conditions as histopathological examination is unlikely to provide useful information:

- Cholestasis of pregnancy
- 'Gritty' placenta
- Pruritus of pregnancy
- Maternal diabetes with normal pregnancy outcome
- Hepatitis B, HIV, etc.
- Other maternal disease with normal pregnancy outcome
- Placenta praevia
- Post-partum haemorrhage
- Polyhydramnios
- Rhesus negative mother with no fetal hydrops
- History of maternal Group B streptococcus
- Maternal coagulopathy
- Maternal substance abuse
- Uncomplicated twin pregnancy
- Congenital anomaly
- Common aneuploidies
- Low grade pyrexia in labour
- History of previous molar pregnancy
- Normal pregnancy
- Accessory lobe
- Uncomplicated velamentous cord

Submission of placentas following other pregnancy complications may depend on the value placed on placental examination in other situations by the senior obstetricians or paediatricians.

NOTE. If the woman specifically requests that her placenta is not sent for histology we must abide by her choice and not send.

What to do when sending the Placenta for Histological Investigation

In Hywel Dda all placentas requiring histopathology examination are sent to GGH Histopathology department.

- Take any required samples for microbiology/cytogenetics before preparing placenta to go to histopathology
- Placentas may be submitted to the laboratory in unfixed state i.e. wrapped in 5 swabs wet with saline. Place placenta on wet swab under the placenta and use remaining four wet swabs to cover it.
- The white container should be of sufficient size to minimise distortion of the specimen and is available on labour ward.
- The specimen container must be labelled with the patient details on an addressograph (on both the lid, and specimen container) and the specimen histopathology request form must be completed (see below) and securely taped to the pot (do not attach to lid).

- During office hours the coordinator must ensure that the placenta is taken straight to histology and given to a member of staff there so they can add formalin.
- Outside of office hours the placenta will remain in the white pot in the Labour Ward fridge and the coordinator each morning will arrange for collection/ delivery to histopathology in GGH. At weekends there is no lab worker in histology so any placentas will have to be sent on the Monday morning.

Important to Note: The placenta wrapped in saline swabs will deteriorate as it unfixed and it is therefore best to transfer to histopathology lab in GGH as soon as possible where formalin will be added so that the placenta is then fixed to stop further deterioration.

Completing the Histopathology Request Form

Completing the request form is the responsibility of the requesting clinician, who must ensure full details are recorded on the pathology request form to enable a thorough examination.

- Mothers full name and hospital number
- Clinical consultant
- Date of birth
- Gestational age and mode of birth
- Live birth or still birth
- Baby weight and sex
- Apgar scores
- Criteria indicating the need for request (see list of indications)
- Ensure that form is secured to the container
- Document in maternal and neonatal records.

Placenta being sent to University Hospital Wales

Placentas being sent to University Hospital Wales (UHW) for histology will be transferred directly in unfixed state to UHW.

Note: GGH histopathology department do not have any involvement in the process or obtain samples/slides from any placenta going directly to UHW Histopathology department.

Disposal of Placenta

Universal Disposal of Placenta

The majority of women will want the midwife to dispose of the placenta which should be done in accord with the health board policy .The placenta should be placed in a placenta container inside a placenta bag. The placenta bag should be labelled with the date and time of birth as well the room number / theatre where the birth took place. The placenta containers should be stored on the labour ward in the freezer for 24 hours.

At a home birth, place the placenta into the orange clinical waste bag and place into a placenta pot. Only after this time should the placenta be transferred by the porters for the appropriate disposal of the placenta in line with the health board policy.

Occasionally parents request to take their placenta home with them.

The Health Board has a responsibility for the safe handling and disposal of all human tissue, including placentae. As placenta is “human tissue” it must be incinerated at a high temperature or buried at a significant depth and not placed in domestic or council waste bins.

Non-Universal Disposal of Placenta

If the woman wishes to take her placenta home to bury, encapsulate or have a lotus birth, she must sign the *“Release of human tissue (placenta and umbilical cord only) to a woman for transfer from hospital premises or to remain at home with the woman”* form (See Appendix 1) and instructions for safe disposal and general guidance should be given.

Guidance on the storage and disposal (by burial) of Placenta

(See Appendix 2)

A placenta provides a perfect environment for micro-organisms to grow. In order to reduce the risk of spreading infections, the following advice should be given:

1. The placenta should be sealed in a plastic bag, this should then be sealed in a second plastic bag. It should then be placed into a leak-proof, sealed container to transport it in. The woman will need to bring the container to hospital with her for the birth. Once sealed, the container should not be opened until it arrives at home.
2. Placenta will deteriorate quickly so needs to be taken home as soon as possible after the birth and stored in a cool place. It should be stored in a fridge that does not contain any food and for no more than 48 – 72 hours before it is buried or disposed of.
3. It is important to remove the placenta from the plastic sealable container and plastic bag prior to burial.
4. When handling the placenta, recommend wearing protective gloves and wash hands well afterwards.
5. The placenta must be buried on private property and not in public places such as parks or cemeteries. Placenta cannot be disposed in domestic or council refuse.
6. If decision made to bury the placenta, it is the woman’s responsibility to ask her local council if there are any applicable guidelines and to follow them. Suggest burying the placenta at a depth of no less than one meter deep to prevent it being dug up by animals and becoming a potential source of infection.
7. If woman decides that she does not want to bury the placenta, it is their responsibility to contact her local council and arrange for the placenta to be disposed of into an appropriate clinical waste system.
8. Woman is required to sign the “*Release of human tissue (placenta and umbilical cord only) to a woman for transfer from hospital premises or to remain at home with the woman”* form. Should it be the intention of the parent to take the placenta overseas for burial, it must be explained to the parent that it is their responsibility to inform the airline of their intention to export human tissue.

The placenta should be preferably be given to the parent. However, should they be remaining in hospital for several days, the partner or close relative may take responsibility for the removal of the placenta.

Note: if the woman has an infection or is a carrier of a blood borne infection, the placenta must be retained by the Trust for disposal by incineration.

Placental Encapsulation

Although there are no clinically proven health benefits, some women choose to take their placentas home for consumption for personal, spiritual or cultural reasons. Give following advice (See Appendix 2).

- Where a woman/person chooses to employ a placental encapsulation company, advise that they must ensure the company is registered as a food business with the local environmental health office and has a food hygiene rating
- If there is a plan to take the placenta for consumption, such as encapsulation, the woman should be advised to discuss with their midwife with the birth preferences
- The company should provide a chiller pack containing everything needed for safe storage of the placenta.
- Once born, the midwife handles the placenta with sterile gloves and places it as soon as possible into the chiller pack.
- Placental remains from the encapsulation process must be treated as human tissue and buried as described above If the woman says that they would be planning to bury the placenta remains please give for the "Information for Women: Transport and Disposal (by Burial) of Placenta at home" leaflet for guidance.
- Woman is required to sign the " *Release of human tissue (placenta and umbilical cord only) to a woman for transfer from hospital premises or to remain at home with the woman"* form.

Lotus Birth

'Lotus birth', also known as "Umbilical Nonseverance", is when the placenta remains attached to the baby until the cord naturally detaches usually 3 to 10 days after birth.

This is rarely seen in the hospital setting and although very uncommon is more likely to be seen in the home or free birth setting. It is important for some people who have specific spiritual and cultural beliefs that the umbilical cord and placenta remain intact.

Unlike the recognised benefits of delayed cord clamping for babies in the limited research available for Lotus Birth there is no medical benefit for the baby to remain attached to the placenta after the cord has stopped pulsating. It recommended that any baby that undergoes lotus birthing be monitored closely for infection. (RCOG) as there known risks for the baby.

If the woman specific wishes are to have a Lotus birth, then general patient advice leaflet (See Appendix 4) the "*Information for Women: Lotus Birth*." leaflet can be given.

Woman is required to sign the "*Release of human tissue (placenta and umbilical cord only) to a woman for transfer from hospital premises or to remain at home with the woman"* form (two copies: one for maternity notes and one copy to be given to the woman).

Documentation

It is expected that every episode of care to be clearly documented and as contemporaneously as possible using the approved Hywel Dda labour and birth / postnatal record. This is in line with standards set by governing professional colleges (NMC, RCOG). All entries must have date and time together with signature and printed name.

Auditable Standards

- Completeness of recording of placental examination
- Clinical indication for referral to Histopathology appropriate
- Release of human tissue (placenta and umbilical cord only) to a woman for transfer from hospital premises or to remain at home with the woman" form is completed

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Appendix 1 – Release of Human Tissue (Placenta and Umbilical Cord only) to a woman for transfer from hospital premises or to remain at home with the woman

Name
DOB
Hospital Number
NHS number
Patient details or addressograph sticky

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The following human tissue removed from the above woman has been released to them on ……. / ……... / …….....

Nature of human tissue being release ……

Storage method for transfer-transport …….....

Tissue given to woman / carer (delete as appropriate)

Authorising member of staff:

Signature.....

Print name .....

Designation ……..

Hywel Dda Site: GGH/ BGH / WGH/ Home

Statement of woman:

I understand that the tissue being released to my care is clinical waste and I will take responsibility for the safe and lawful storage and disposal of this material.

Name of recipient of tissue …….

Relationship (if not woman) ……

Signature …….. Date…… / ……... / ……...

(Copy to maternity notes and copy to woman)

Appendix 2 – Information for Women: Guidance on the storage and disposal (By Burial) of placenta

This information is intended to guide you through how to safely transport and/or dispose of your placenta if you have decided to take it home with you or keep it at home (following birthing at home).

There are some standard precautions you should be aware of for your health and safety and that of others in your home. It is also important that you are aware of how to dispose of your placenta in accordance with laws designed to protect public health, or what you should do if you decide to bury it.

A placenta provides a perfect environment for micro-organisms to grow. In order to reduce the risk of spreading infections, the following steps should be followed:

1. The placenta should be sealed in a plastic bag, this should then be sealed in a second plastic bag. It should then be placed into a leak-proof, sealed container to transport it in. You will need to bring the container to hospital with you for the birth. Once sealed, the container should not be opened until you arrive home.

2. Placenta will deteriorate quickly so needs to be taken home as soon as possible after the birth and stored in a cool place. It should be stored in a fridge that does not contain any food and for no more than 48 – 72 hours before it is buried or disposed of.

3. It is important to remove the placenta from the plastic sealable container and plastic bag prior to burial.

4. When handling the placenta, we recommend that you wear protective gloves and wash your hands well afterwards.

5. The placenta must be buried on private property (your own garden for example) and not in public places such as parks or cemeteries. You cannot dispose of your placenta in domestic or council refuse.

6. If you decide to bury your placenta, it is your responsibility to ask your local council if there are any applicable guidelines and to follow them. We suggest that you bury your placenta at a depth of no less than one meter deep to prevent it being dug up by animals and becoming a potential source of infection.

7. The place where the placenta is buried should be marked in some way so that it is not accidentally disturbed at a later date

8. If you change your mind and decide that you do not want to bury your placenta, it is then your responsibility to contact your local council and arrange for your placenta to be disposed of into an appropriate clinical waste system

9. We will ask you to sign the ““*Release of human tissue (placenta and umbilical cord only)“* form.

10. Should it be your intention to take the placenta overseas for burial please understand that it is your responsibility to ensure that you have informed the airline of your intention to export human tissue.

11. The placenta should be preferably be given to the mother. However, should you be remaining in hospital for several days, the partner or close relative may take responsibility for the removal of the placenta.

Please Note: if the woman has an infection or is a carrier of a blood borne infection, the placenta must be retained by the Health Board for disposal by incineration.

Appendix 3 – Information for Women: advice when deciding to have Placental Encapsulation

This information is intended to guide women who choose to take their placentas home for consumption (via encapsulation) for personal, spiritual or cultural reasons.

1. If you choses to employ a placental encapsulation company we advise that you ensure the company is registered as a food business with the local environmental health office and has a food hygiene rating as Placenta service providers are now regulated by the Foods Standard Agency .

2. If there is a plan to take the placenta for consumption, such as encapsulation, you must tell your midwife before the birth.

3. A placenta provides a perfect environment for micro-organisms to grow. In order to reduce the risk of spreading infections the company should provide a chiller pack containing everything needed for safe storage of the placenta.

4. Once born, the midwife handles the placenta with sterile gloves and places it as soon as possible into the chiller pack.

5. If there are any placental remains from the encapsulation process it must be treated as human tissue and buried.

Additional information:
If you are planning to bury your placenta remains please ask for the “Information for Women: Transport and Disposal (by Burial) of Placenta at home” leaflet for guidance. It explains some standard precautions to be aware of for your health and safety as well as others in your home as well as how to dispose of /bury your placenta in accordance with laws designed to protect public health.

We will ask you to sign the: *Release of human tissue (placenta and umbilical cord only)* form.

Appendix 4 – Information for Women: Lotus Birth

A Lotus birth', also known as "Umbilical Nonseverance", is when the placenta remains attached to the baby until the cord naturally detaches usually 3 to 10 days after birth. A Lotus Birth is rarely seen in the hospital setting and, although occurrence is very uncommon, is more likely to be seen in the home or free birth setting. It is important for some people who have specific spiritual and cultural beliefs that the umbilical cord and placenta remain intact.

The usual practice following birth is to place your baby 'skin-to-skin' as soon as possible, whilst the placenta is delivered. Once the blood flow between the placenta and your baby has ceased, and no pulse is felt in the cord, your midwife or doctor would normally assist you to clamp and cut the cord. Unlike the recognised benefits of delayed cord clamping for babies in the limited research available for Lotus Birth there is no medical benefit for the baby to remain attached to the placenta after the cord has stopped pulsating.

If you are planning to have a Lotus Birth please discuss with your midwife when discussing your birth preferences. When you decide to have a lotus birth please understand that it will the responsibility of the mother to monitor the placenta/cord as whilst your midwife is supporting your choice they cannot take responsibility.

It is recommended that any baby that undergoes lotus birthing be monitored closely for infection) as there are known risks, including infection, for the baby.

Following your baby's Birth

- Once the placenta is birthed the midwife will examine the placenta and membranes for completion.
- Any excess fluids should be wiped off from the placenta and cord, if necessary, wash it clean, and carefully pat it dry.
- The placenta is then usually wrapped in a cloth (provided by the woman) but when at home this may be placed in a covered bowl.
- Keep the placenta near your baby and lift or hold the baby carefully with clean, thoroughly washed hands to reduce the chances of the cord being tugged, which could potentially cause the cord to be pulled out before it's ready to fall off.
- Dress your baby in loose, comfortable clothing that opens in the front too. It is important that the air is able to pass through the cloth or the bowl to allow the placenta to dry out to aid separation, thus preventing a distinctive musky odour.
- Do not attempt to remove the umbilical cord. It should fall off naturally within three to 10 days after birth, but in some cases it could take up to 15 days. If you change your mind and decide that you want to remove the umbilical cord before it's ready to fall off, please contact the community midwife for advice.
- Some women may speed up this process by adding sea salt or essential oils however they haven't been proved to reduce the risk of infection.

You will need to pay attention, for signs of a possible infection in the baby. Seek immediate medical care for:

- A pus or fluid-filled lump near the umbilical cord area.
- Red, warm or swollen skin near the umbilical cord area.

- Cloudy, foul-smelling discharge or blood coming from the umbilical cord or navel area.
- If you have a thermometer at home and your baby has a raised, low or fluctuating temperature (temperature should be between 36.6 and 37.4 degree celcius)
- If your baby is limp, increasingly Irritability, lethargy, increasingly sleepy or difficult to rouse, decreased activity
- Has abnormal or rapid breathing
- Your baby is not feeding well
- You are concerned

Additional considerations when planning a Lotus Birth

If you have requested a lotus birth, please be mindful that if an emergency presents (such as haemorrhage or your baby needs resuscitation), your care providers will ask for your consent to clamp and cut the umbilical cord in order to initiate emergency care for you and/or your newborn.

The care and disposal of the placenta remains remain your responsibility. Your midwife will be able to provide you with and information leaflet called "*Information for Women: Guidance on the storage and disposal (by burial) of placenta".*

We will ask you to complete the "*Release of human tissue (placenta and umbilical cord only) " form.*