UNIT NO.

NAME

BIRTH DATE:

VISIT NUMBER:

(If handwritten, record name, unit no., birth date, and visit no.)

YALE-NEW HAVEN HOSPITAL
CONSULTATION:
Request for
POST-MORTEM EXAMINATION

To: Department of Pathology, Division of Autopsy Services

From: _____ Date of Request: ___/___/___
Service/Department *Floor / Location*

Clinical Team Members:

Please list the names and beeper or phone numbers for **every member of the clinical team involved in the care of this patient** (attending physician, residents, interns, etc.) who would like to be informed of the autopsy findings:

Name (Please Print)	Office/Beeper #	Would like to attend autopsy	Would like to attend organ review	Call with results.	Send Report
		❑	❑	❑	❑
		❑	❑	❑	❑
		❑	❑	❑	❑
		❑	❑	❑	❑

Clinical Information:

Major Clinical Diagnoses (Problem List; include significant past medical history): _____

Clinical Course: _____

Terminal Event: _____

Specific Questions to be Addressed: _____

Completed by (signature): _____

Printed name: _____ Date: _____ Time: _____

NOTE: Permission form on back MUST BE COMPLETED

CONSENT FOR POST-MORTEM EXAMINATION

I, _____ , the _____ of the
Name of person giving consent (Please Print) *Relationship to the deceased (Please Print)*
deceased and entitled by law to control the disposition of the body, hereby request that the pathologists at Yale-New Haven Hospital perform an autopsy on the remains of _____ ,
Name of deceased (Please Print)
for whom I assume responsibility for burial.

1. I understand that any diagnostic information gained from the autopsy will become part of the deceased's Hospital medical record.
2. I agree to the removal, examination, and retention of organs, tissues, prosthetic devices, and fluids as the pathologists deem proper for diagnostic, education, quality improvement and research purposes.
3. I agree to the eventual disposition of these materials as the pathologists or the hospital determine.
4. This consent does not extend to removal or use of any of these materials for transplantation or similar purposes, which requires a separate permission.
5. I understand that organs and tissues not needed for diagnostic, education, quality improvement, or research purposes will be sent to the funeral home with the body.
6. I understand that I may place some limitations on both the retention of organs and the extent of the autopsy. I understand that any limitations may compromise the diagnostic value of the autopsy or may limit the usefulness of the autopsy for education, quality improvement, or research purposes.
7. I have received or been read the Hospital's "Patient Rights" statement and understand that I have the right to arrange for the autopsy to be performed elsewhere, but prefer to have it performed at Yale-New Haven Hospital.
8. I have been given the opportunity to ask any questions that I may have regarding the scope or purpose of the autopsy.
9. I understand that **IF** this death occured at Yale-New Haven Hospital, Saint Raphael Campus. Yale-New Haven Hospital will make arrangements for the transportation of the body to Yale-New Haven Hospital Morgue, York Street campus, where the autopsy will be performed and from where the body will be released to the funeral home of my choice.

Limitations: ❑ None (Permission is granted for a complete autopsy, with removal, examination, and retention of material as the pathologists deem proper for the purposes listed above)

❑ Permission is granted as described above with the following limitations (specify):

_____

_____

_____ _____ _____
Signature of person consenting to the autopsy *Date* *Time*

_____ _____
Address of person consenting to the autopsy *Phone number of person consenting to the autopsy*

_____ _____
Signature of person obtaining permission *Printed name of person obtaining permission*

❑ Permission was obtained by telephone. The above statements were read by the "person obtaining permission" to the above named person, and agreed to. This phone conversation was witnessed by:

_____ _____
Signature of witness *Printed name of witness*

_____ _____
Date *Time*

INSTRUCTIONS: To be valid, this document 1) must be dated, 2) must be signed by the person obtaining permission, AND 3) must be signed either by the person granting permission or the witness monitoring the phone call in which permission was given.

NOTE: Please complete the CONSULTATION REQUEST form on the front