Mount Sinai

REQUEST FOR POST-MORTEM EXAMINATION

Patient Care Unit: _____ Primary Attending: _____

Date of Death:_____ Time of Death: _____(AM/PM)

PERMISSION:

I, (printed name) _____, the (relationship to the deceased) _____of the deceased (name), _____, being entitled by law to control the disposition of the remains (priority Next-of-kin), hereby request the pathologists of (name of hospital) _____to perform an autopsy on the body of said deceased. I understand that any diagnostic information gained from the autopsy will become part of the deceased's medical record and will be subject to applicable disclosure laws.

Retention of Organs/Tissues:

I authorize the removal, examination, and retention of organs, tissues, prosthetic and implantable devices, and fluids as the pathologists deem proper for diagnostic, education, quality improvement and research purposes. I further agree to the eventual disposition of these materials as the pathologists or the hospital determine or as required by law. This consent does not extend to removal or use of any of these materials for transplantation or similar purposes. I understand that organs and tissues not needed for diagnostic, education quality improvement, or research purposes will be sent to the funeral home or disposed of appropriately.

I understand that I may place limitations on both the extent of the autopsy and on the retention of organs, tissues, and devices. I understand that any limitations may compromise the diagnostic value of the autopsy and may limit the usefulness of the autopsy for education, quality improvement, or research purposes. I have been given the opportunity to ask questions that I may have regarding the scope or purpose of the autopsy.

Limitations: ☐ None. Permission is granted for a complete autopsy, with removal, examination, and retention of material as the pathologists deem proper for the purposes set forth above, and for disposition of such material as the pathologists or the hospital determine; or

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☐ **P**ermission is granted for an autopsy with the following limitations and conditions (specified):

_____

_____

_____MD _____

(SIGNATURE OF WITNESS) (SIGNATURE OF AUTHORIZING PERSON)

_____MD _____

(PRINT NAME OF WITNESS) (PRINT NAME OF AUTHORIZING PERSON)

DATE_____TIME_____(AM/PM) _____

(RELATIONSHIP TO DECEASED)

Name of Physician(s) to whom report should be sent:

☐ Attending Physician ☐ Others 1._____ 2._____

COMPLETED FORM MUST BE FAXED TO 212-876-4036

Order of priority for NEXT-OF-KIN [AGE EIGHTEEN YEARS OF AGE OR OLDER]:

1. PERSON DESIGNATED IN WRITTEN WILL OR LEGAL INSTRUMENT; OR
2. DECEDENT'S SURVIVING SPOUSE; OR
3. DECEDENT'S SURVIVING DOMESTIC PARTNER; OR
4. DECEDENT'S SURVIVING CHILDREN; OR
5. DECEDENT'S GRANDCHILDREN; OR
6. EITHER OF THE DECEDENT'S SURVIVING PARENTS; OR
7. ANY OF THE DECEDENT'S SURVIVING SIBLINGS; OR
8. ANY OF THE DECEDENT'S GRANDPARENTS; OR
9. ANY OF THE DECEDENT'S AUNTS, UNCLES; OR
10. ANY OF THE DECEDENT'S NIECES OR NEPHEWS; OR
11. AN APPOINTED GAURDIAN; OR
12. PUBLIC ADMINISTRATOR ACTING ON BEHALF OF THE DECEDENT

NOTE: After internal processing, forward to MSH Medical Records for scanning into the legal medical record. Location: Annenberg B2, Room 20 or Mailbox 1111