OSUWMC Pathologists review medical records before every autopsy. If the review shows that the case must be reported to the county coroner, a representative of the OSUWMC Regional Autopsy Center will do so. Contact the Regional Autopsy Center with questions.

I give permission to the doctors and staff of The Ohio State University Wexner Medical Center (OSUWMC) to do:

**AN AUTOPSY FOR DIAGNOSIS:** I understand that organs, fluids, and pieces of tissue will be removed, retained, and potentially used for educational purposes, research, or scientific study, including the possible gathering of genetic material or deposit in a tissue bank. Images may also be used for these purposes. (Select an autopsy type.)

☐ A complete autopsy to try to find the cause of death.

☐ *A complete autopsy excluding (list exclusions): _____ .

☐ *A limited autopsy to include (list inclusions): _____ .

*Any selection other than a complete autopsy may not provide sufficient information for a cause of death statement.

**AN AUTOPSY FOR REMOVAL RELEASE ONLY:**

☐ Removal of _____ with no testing performed and release to _____ . A release form may be required.

☐ Removal of _____ for research purposes only and release to _____ . Documentation of a research protocol, along with other research-specific documents, is required.

I am the legal next-of-kin (see back of form) and give permission for this autopsy on the body of _____ .

I have provided the names of all of the legal next-of-kin known to me.

I grant permission for the *Preliminary* and *Final Autopsy Reports* to be sent to the following physicians (include phone numbers):_____ .

_____ .

**List physicians on the lines above. Do not include physician information in boxes below.**

| **Next of Kin Name** | **Next of Kin Address & Phone** | **Next of Kin Signature** |
|---|---|---|
| Print Name:<br><br>Relationship: | Address:<br><br>Phone: | |
| Print Name:<br><br>Relationship: | Address:<br><br>Phone: | |
| Print Name:<br><br>Relationship: | Address:<br><br>Phone: | |
| Print Name:<br><br>Relationship: | Address:<br><br>Phone: | |

Witness Signature (optional): _____ Date: _____ Time: _____

*FS0069*

**CHECK ONE (REQUIRED):**

❑ **THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER**
❑ **ARTHUR G. JAMES CANCER HOSPITAL & RICHARD J. SOLOVE RESEARCH INSTITUTE**
❑ **WEXNER MEDICAL CENTER AMBULATORY SURGERY CENTER**

## AUTOPSY CONSENT FORM

THC202133 (10/22)

**Patient Name:**

**Medical Record Number:**

**Date of Birth:**

## OBTAINING CONSENT

1. Place a patient label on (or hand-write the patient information in) the front lower right corner.
2. Reasonable efforts must be made to locate the legal next-of-kin to obtain consent.
3. Determine the most appropriate individual(s) according to Ohio Revised Code 2108.81 in the following order:
   a. Decedent prior to expiration.
   b. Any adult included on a Written Disposition Declaration executed by the decedent. The original document must be presented.
   c. Surviving spouse.
   d. Surviving child or majority of surviving children if there is more than one surviving child.
   e. Surviving parents. If both parents are surviving, both are required to sign for consent.
   f. Surviving sibling or majority of surviving siblings if there is more than one surviving sibling.
   g. Surviving grandparents or majority of surviving grandparents if there is more than one surviving grandparent.
   h. Surviving grandchild or majority of surviving grandchildren if there is more than one surviving grandchild.
   i. Next closest relative(s).
   j. Individual who was decedent's appointed guardian at the time of death.
   k. Any other individual willing to assume the right of disposition, including the personal representative of the decedent's estate, after attesting in writing that a good faith effort was made to locate the legal next-of-kin.
4. All persons giving consent must be 18 years of age or older.
5. If one of the class of next-of-kin cannot be located, the decision should be made by the majority of the individuals in the class that are located.
6. If there is disagreement amongst members of the same class, consent must be obtained from the majority of the members of that class.
7. Consent is only accepted in writing with a valid signature (digital signatures are not accepted). Verbal consents are accepted in emergency situations only and per the pathologist.
8. There is no base autopsy fee if the decedent was admitted to an OSUWMC facility within the last two years. Other fees such as transportation and additional studies may apply.
9. Autopsies are performed at the OSU Wexner Medical Center.

## REPORTING

**OSUWMC Families and Families of Other Medical Facilities**

Autopsy reports are sent to the attending physician and any other physician(s) designated by the legal next-of-kin. A letter is mailed to the families upon completion of the *Final Autopsy Report,* typically within 45-60 working days that will contain instructions for obtaining a copy of the Report. Families are encouraged to contact the Medical Information Management Department of the medical facility (e.g. OSUWMC) to request reports.

**Private Autopsy Requests**

A *Preliminary Autopsy Report* is sent to all consenting next-of-kin, the attending physician, and any other physician(s) designated by the next-of-kin, within 5 working days of the autopsy. *The Final Autopsy Report* is completed following a review of microscopic findings, the patient's clinical history, and the results of special studies. The *Final Autopsy Report* is sent to the above-listed individuals once complete, typically within 45-60 working days.

*FS0069*

**Patient Name:**

**Medical Record Number:**

**Date of Birth:**

# AUTOPSY CONSENT FORM

THC202133 (10/22)