

PATIENT INFORMATION SECTION

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

- A complete autopsy to try to find the cause of death. I understand that this may involve examining the entire body. I also understand that organs, fluids, and pieces of tissue will be removed, retained, and potentially used for educational purposes, research, or scientific study, including possible gathering of genetic material or deposit in a tissue bank. Images may also be taken and used for these purposes.
- A limited autopsy to include \_\_\_\_\_. I understand that organs, fluids, and pieces of tissue will be removed, retained, and potentially used for educational purposes, research, or scientific study, including possible gathering of genetic material or deposit in a tissue bank. Images may also be taken and used for these purposes.

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

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

Name	Address & Phone Number	Signature
Print Name:	Address:	
Relationship:	Phone:	
Print Name:	Address:	
Relationship:	Phone:	

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Maternal History: \_\_\_\_\_

Abnormal Findings / Prenatal Ultrasound Findings: \_\_\_\_\_

Results of Fetal Echo / MRI: \_\_\_\_\_

Differential Diagnoses to be Considered / Questions to be Answered: \_\_\_\_\_

Karyotyping on Fetal Tissue Requested:  Yes  No

Previously Ordered On:  Amniocentesis  
 Cord Blood  
 Placenta

Autopsies are performed at OSUWMC. An autopsy may ONLY be requested from Nationwide Children's Hospital (NCH) if the mother was enrolled in the NCH Fetal Medicine Clinic.

CLINICAL HISTORY SECTION



\*INFCON\*

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

INFANT AUTOPSY CONSENT

Patient Name:

Medical Record Number:

Date of Birth:

OBTAINING CONSENT

**Infant Autopsy Consent Instructions**

1. Place a patient label on (or hand-write the patient information in) the front lower right corner.
2. All persons giving consent must be 18 years of age or older.
3. 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.
4. Signature of one parent is sufficient. If parents were never married, only the mother may sign, unless the father has established his parental rights through the Courts.

REPORTING

**OSUWMC Families and Families of Other Facilities**

Autopsy reports are sent to the attending physician and any other physicians designated by the legal next-of-kin (LNOK). A letter is mailed to the families upon completion of the *Final Autopsy Report*, typically within 45-60 working days. Families of OSUWMC patients may contact the OSUWMC Medical Information Management Department to request reports. Families of other facilities are able to request copies of the reports through the appropriate facility's Medical Records Department.

**Private Autopsy Requests**

A *Preliminary Autopsy Report* is sent to all consenting LNOK, the attending physician, and any other physicians designated by the LNOK 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. It is sent to the same individuals once complete, typically within 45-60 working days.



\*INFCON\*

Patient Name:

Medical Record Number:

Date of Birth:

**INFANT AUTOPSY CONSENT**