

I. Patient Information	<input type="checkbox"/> Stillbirth less than 20 weeks <input type="checkbox"/> Stillbirth greater than or equal to 20 weeks <input type="checkbox"/> Live birth			
	Mother's name:			Phone: (    )
	Date delivered:	Time delivered:	Weight:	Sex:                      Race:
	If live birth, Date expired:		Time expired:	LOOP Referral number:
	Attending physician completing Death Certificate:			
Coroner Notified (see reverse for indications): <input type="checkbox"/> Yes <input type="checkbox"/> No                              Assuming jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No				
II. Less Than 20 Week Stillbirth	_____ (mother's name) was pregnant. On ___/___/___ she had a spontaneous miscarriage of a/an _____ week fetus. Physician's Signature: _____ Date / Time: _____ Physician's Printed Name: _____ This statement may be used to register your miscarriage with the State of Ohio and receive a fetal death certificate if you choose. This can be done by contacting the Columbus Department of Vital Statistics at 614-466-2531.			
	Please select one of the 3 options below for handling the remains:			
	<input type="checkbox"/> I authorize the Ohio State University Wexner Medical Center Surgical Pathology Department to dispose of the remains by incineration with other human tissue, and to dispose of the ashes at no cost to me.			
	<input type="checkbox"/> I have made private funeral arrangements. I authorize The Ohio State University Wexner Medical Center to release the remains to: Funeral Home: _____ Phone Number: (_____) _____			
	<input type="checkbox"/> I have other private, cultural or religious arrangements and request for release of the remains directly to me from the Surgical Pathology Department. I understand that I will need to sign "Release of Miscarriage Less Than 20 Weeks" form in order to receive the remains.			
Surgical Pathology Examination: <input type="checkbox"/> Yes <input type="checkbox"/> No                              If yes, Karyotyping? <input type="checkbox"/> Yes <input type="checkbox"/> No				
III. Stillbirth Greater than or Equal to 20 Weeks or Live Birth	Please select one of the 2 options below for handling the remains:			
	<input type="checkbox"/> I authorize the Ohio State University Wexner Medical Center to arrange a cremation through a local funeral home and prepare the documents necessary to complete this process. The ashes can be obtained from the funeral home or will be inurned at a local cemetery. I want the ashes: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	<input type="checkbox"/> I have made private funeral arrangements. I authorize the Ohio State University Wexner Medical Center to release the remains to: Funeral Home: _____ Phone Number: (_____) _____			
Consent for Autopsy: <input type="checkbox"/> Yes <input type="checkbox"/> No                              If yes, complete autopsy consent form				
IV. Permission for Release	Legal Next of Kin Signature:			Date/Time:
	Witness:			
	Received by:		Funeral Home:	Date/Time:



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**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

**INFANT DISPOSITION FORM**

White: Chart    Yellow: Bereavement    Pink: Morgue/Surg path

THC010980 (11/21)

Patient Name:

Medical Record Number:

Date of Birth:

## Instructions for Infant Disposition Form

### Part I: Patient Information

1. Place patient labels on each page of this form.
2. Complete all requested information on infant.
3. Notify LOOP Donor Referral Line at 1-877-223-6667 for all live births followed by death.
4. Indicate attending physician to sign death certificate if infant was a live birth.
5. Report death to Franklin County Coroner at 614-525-5290 in the following circumstances:
  - a. Stillborn or newborn infant death where there is a recent or past traumatic event involving the mother, such as vehicular accident, homicide, suicide attempt or drug ingestion that may have precipitated delivery or had a detrimental effect to the newborn.
  - b. If the death occurs when in apparent good health or in any suspicious or unusual manner, including Sudden Infant Death Syndrome.
  - c. All stillborn infants where there is suspected or actual injury to the mother.
  - d. Any maternal or infant death where there is suspicious or illegal interference by unethical or unqualified persons or self-induction.
  - e. Any accidental death while in the hospital.

### Part II: Less than 20 Week Stillbirth

1. Complete the statement of miscarriage and sign.
2. Discuss the disposition options with the mother and indicate her preference on the form.
3. Indicate whether a surgical pathology examination and karyotyping will be completed.
4. All copies of this form should be sent with remains to Surgical Pathology.

### Part III: Greater than 20 Week Stillbirth or Live Birth

1. Discuss the disposition options with the mother and indicate her preference on the form.
2. If the mother would like an autopsy, complete the Infant Autopsy Consent Form.
3. All copies of this form should be sent with remains to OSU morgue.

### Part IV: Permission for Release

1. The mother or father, if married, must sign the form in order to release the infant's body to the designated facility.
2. Sign the form as a witness.
3. If the family is unsure of their wishes while in the hospital, they may call Decedent Affairs with their decision after they go home at 614-293-3865.



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**INFANT DISPOSITION FORM**

**Patient Name:**

**Medical Record Number:**

**Date of Birth:**