Autopsy Consent

Consent

Legal Next of Kin Ranked in Order of Authority:

1. Personal representative of deceased, as named in will of deceased;
2. Legal spouse / adult interdependent partner of deceased;
3. Adult children of the deceased (oldest first);
4. Parents of deceased (oldest first);
5. If patient was a Dependent Adult or, if a minor, a ward of the Province, the patient's Guardian;
6. Adult grandchildren of the deceased (oldest first);
7. Adult siblings / sisters of the deceased (oldest first);
8. Adult nephews or nieces of the deceased (oldest first);
9. Any other Adult next of kin (oldest first);
10. Any person lawfully in possession of the body.

Note: If next of kin higher in the ranking list are alive and mentally competent, they must sign the consent.
If we are aware of any dissension amongst family members, the autopsy will not be performed.
(See section 36, Funeral Services General Regulation, AR 226 / 98)

I am the (relationship) __________________________ of the deceased and, to the best of my knowledge, I am the highest legal next of kin ranked in order of authority (see above).
I do hereby authorize the designated authorities of Capital Health / DynaLIFE to perform a: (please check appropriate box for type of autopsy to be performed)

- [ ] Complete Autopsy Examination
- [ ] Partial Autopsy Examination (please specify) __________________________
on the body of said patient.
I authorize and direct the removal, use and disposal of such organs or tissue as may be necessary or desirable for pathological diagnosis, therapeutic purposes, medical education or medical research OR the following restrictions apply:

It is understood that reasonable care will be taken to avoid disfigurement of the body.
Upon completion of the autopsy, I authorize the body to be released to:

Funeral Home / Designate: ____________________________________________________________

Funeral Home / Designate Phone Number: _____________________________________________

Note: If unknown, the Funeral Home of your choice will contact Patient Registration / Admitting Department when arrangements are made.

Sign Here

__________________________  _____________________________
Next of Kin: Please print name  Next of Kin: Please sign

Date and time of Authorization: _______________________________________________________

Witness(es)

Witness # 1 _____________________________
(Physician or delegate - please print name)  Witness # 1 signature

For phone consent, an additional witness is required:

Witness # 2 _____________________________
(Witness # 2 - please print name)  Witness # 2 signature

Please complete consultation request on reverse.
Anatomical Pathology
Autopsy Consultation Request

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Legal Name (Last)</td>
<td>(First) (Initial)</td>
</tr>
<tr>
<td>Address</td>
<td>City, Prov., Postal Code</td>
</tr>
<tr>
<td>Chart #</td>
<td>Patient Phone #, Lab #</td>
</tr>
<tr>
<td>Ordering Physician / Practitioner</td>
<td>Physician Code</td>
</tr>
<tr>
<td>Ordering Address / Location</td>
<td>Report Location Code</td>
</tr>
<tr>
<td>Bill Type</td>
<td>CPL: Alberta Health Care, CCO: Capital Health Company, CO: Company XX, OT: Out of Prov, PB: Pre-paid, Patient Bill</td>
</tr>
<tr>
<td>Co. name</td>
<td>Address</td>
</tr>
<tr>
<td>Client #</td>
<td></td>
</tr>
<tr>
<td>Date and Time of Death</td>
<td>DD MM YY, Time (24 h)</td>
</tr>
</tbody>
</table>

Refer to Regional Autopsy Information "Process for Initiation, Communication, and Completion of An Autopsy (Post Mortem Examination)" for details on process.

**Brief Clinical History and Unresolved Clinical Questions:**

**Note:** Failure to provide adequate information may delay or cancel a request for autopsy on patient.

Please check appropriate box:

- HIV Test:
  - Positive
  - Negative
  - Pending
  - Not ordered (but patient in high risk group)
  - Unknown

- Hepatitis B or C Test:
  - Positive
  - Negative
  - Pending
  - Unknown

- TB
  - Other communicable disease: ____________

- Suspect prion disease
  - If checked, follow CJD Process outlined in Regional Autopsy Information "Process for Initiation, Communication, and Completion of an Autopsy (Post Mortem Examination)".

Complete the History Questionnaire for Neuropathological Examination on Patients with Dementia (Form can be found on the University of Alberta Hospital Online Guide to Laboratory Services Manual under the "Requisition" link.)

**Note:** Affirmative answers to some of the above questions will not preclude performance of autopsy.

Physician Signature: ________________________________ Date: __________________________

Report Address (if different from above): ________________________________

If interested in preliminary results by phone, please provide name and phone / pager #: ________________________________

For Lab Use Only:

- Date and Time of Autopsy: ________________________________
- Pathologist: ________________________________
- Resident (if applicable): ________________________________

AP Accession Number

Please complete Autopsy Consent on reverse.