Alberta Health Services | Covenant Health

PHN / Healthcare # _____

Chart / Record # _____

Patient Legal Name: Last: _____

First: _____

Physician: _____

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 brothers / 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 authorized the designated authorities of Capital Health / ***Dyna*LIFE**$_{DX}$

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.

PHN / Healthcare Number

Anatomical Pathology
Autopsy Consultation Request

LABORATORY MEDICINE AND PATHOLOGY
Client Response Centre 780-407-7484
CAPITAL HEALTH REGION LABORATORIES
DynaLIFE$_{DX}$ DIAGNOSTIC LABORATORY SERVICES

☐ M ☐ F | Patient Legal Name (Last) (First) (Initial) | DOB DD MM YY

Full Name & Location MUST BE PROVIDED

☐ Copy to
Name _____
Physician Code _____
Address _____
_____

Address | City | Prov. | Postal Code

Chart # | Patient Phone # | Lab #

Ordering Physician / Practitioner | Physician Code

Ordering Address / Location | Report Location Code

Report address if different

Specimen Event Type
IA ☐ AUXILIARY
IP ☐ IN PT
OP ☐ OUT PT
AP ☐ AMBUL
HC ☐ HMCARE
ST ☐ STAFF
EN ☐ ENVIRON
WCB ☐ WORKER'S COMP

Bill Type CPL ☐ Alberta Health Care
CCO ☐ Capital Health Company
CO ☐ Company XX ☐ Pre-paid
OT ☐ Out of Prov PB ☐ Patient Bill
Co. name _____
Address _____
Client # _____

Date and Time of Death
DD | MM | YY | Time (24 h)

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.