Alberta Health Services

Affix patient label within this box

Consent for Autopsy

To be completed by the legal representative in consultation with the physician.

General

I am the *(relationship)* _____ of *(name of deceased)* _____.
To the best of my knowledge, I am the highest ranked authorized representative available to give this consent, and the personal representative named in the Will of the deceased is either not known or does not object to an autopsy being performed.

Authorized representative listed in order of authority

- ☐ 1. Spouse/adult interdependent partner living with deceased at time of death or personal representative of the deceased as named in the Will of the deceased
- ☐ 2. Adult daughter or son
- ☐ 3. Parent
- ☐ 4. Adult sister or brother
- ☐ 5. Grandparent
- ☐ 6. Adult Grandchild
- ☐ 7. Adult aunt or uncle
- ☐ 8. Adult niece or nephew
- ☐ 9. Person lawfully in possession of the body

At the time of death the deceased was

- ☐ Married/Interdependent Relationship
- ☐ Divorced
- ☐ Single
- ☐ Separated
- ☐ Widowed
- ☐ Unknown status

The reason for performing an autopsy and the procedure involved have been explained to me and I understand that:

- This autopsy is not required by law. It is carried out to understand the cause of death, to study the effects of treatment, and to gather medical knowledge.
- Retention of tissue(s), organs and/or fluid(s) removed during the autopsy is required for complete diagnostic testing. These specimens may be used for quality assurance purposes and approved education, and will be disposed of in accordance with approved laboratory standards.
- I can state limitations about the autopsy and the removal and retention of tissues and organs.
- I may withdraw or modify this consent before the autopsy has taken place.
- Information about the results of the autopsy should be obtained from the patient's doctor.

Consent for Autopsy

I hereby give permission for an autopsy to be performed on the body of _____.
I give permission for

- ☐ A complete autopsy - including the removal of tissue and organs during the examination.
- ☐ A limited autopsy *(please specify limitation(s)*

Instructions for fetal remains

Remains to be cared for by ☐ Funeral Home ☐ Cremation Program *(Less than 20 weeks)* ☐ Family

Consent for Retention of Organs/Tissue for Education and Research

- ☐ I consent to bodily tissue and organs removed at autopsy being kept for future medical education and research.
- ☐ I do not consent to bodily tissue and organs removed at autopsy being kept for future medical education and research.

Special Instructions and/or Limitations *(please specify)*

Please completed Side B

Alberta Health Services

Consent for Autopsy

Signatures *(Note: Physician obtaining consent may not witness signatures)*		
Signature of Authorized Representative	Name	Date *(yyyy-Mon-dd)*
Signature of witness *(to signature or telephone conversation)*	Name	Date *(yyyy-Mon-dd)*
Second witness required when telephone consent obtained by hospital staff		
Signature of second witness *(to telephone consent)*	Name	Date *(yyyy-Mon-dd)*

Consultation Request *(to be completed by the physician requesting the autopsy)*

Autopsy may be delayed if this information is not complete

Autopsy requested by _____ _____ _____
Physician *Phone No.* *Pager No.*

Date and time of death _____ at _____
Location at death e.g. home, hospital, hospice,etc

Infectious disease known or suspected:
☐ No
☐ Yes (*please specify)*_____
Note: The autopsy may be restricted for safety reasons

Clinical Summary *(include anatomical and radiological findings relevant to the autopsy, as well as pertinent laboratory data)*

_____

_____

_____

_____

State problems to be elucidated at autopsy

_____

_____

Doctor(s) wishing to attend autopsy (*print name and give telephone or pager number)*

_____

Doctor(s) requiring report *(please include family physician)*

_____

VI. Signature of Physician or Designate Obtaining Consent	
Signature of Physician *(or designate)* Obtaining Consent	Printed name and Phone or Pager number