THE University of Vermont MEDICAL CENTER

Pathology & Laboratory Medicine

Deceased Full Name:
Date of Birth
MRN:

CONSENT FOR POST-MORTEM EXAMINATION

The post-mortem examination (autopsy) is a medical procedure that is performed to learn more about the cause of death and the reasons for that death. Many families find this helpful. Each examination also contributes to our medical knowledge and can help other patients who have the same problems. The examination uses surgical incisions to allow observation and removal of organs. These incisions will not involve the face or any other part of the body that would be visible during viewing. The clothed body will look the same with or without the postmortem examination.

I GRANT PERMISSION TO THE DOCTORS OF THE UNIVERSITY OF VERMONT MEDICAL CENTER AND THEIR ASSISTANTS TO PERFORM AN AUTOPSY ON THE DECEASED BODY OF _____.
Print Full Name of Deceased

I authorize the examination, removal, imaging, and retention of organs, tissues, implanted devices, and fluids as the pathologists deem necessary for diagnosis, education, research, and quality improvement. I understand that the remaining organs and tissues will be disposed of appropriately and in accordance with the law.

I UNDERSTAND MY RIGHTS

I understand I have the right to limit the extent of the examination or the retention or imaging of organs, tissues, or devices. I understand that limitations may decrease the information obtained from the examination. I understand any organs kept by the hospital may be used for teaching and research to help others and that if organs are used for these purposes all identifying information will be anonymized. I have been given the opportunity to ask any questions that I may have regarding the scope or purpose of the procedure.

I AUTHORIZE:

- ☐ Complete Autopsy (no restrictions)
- ☐ Autopsy restricted by the following conditions:_____

I represent that I am the nearest next-of-kin of the deceased and entitled by law to control the disposition of the remains.

_____	_____	_____
Print Full Name of Person Authorizing Autopsy	Signature of Person Authorizing Autopsy	Date & Time
_____	_____	_____
Relationship to Deceased	Mailing Address	Telephone Number

PERMISSION OBTAINED BY:

_____	_____	_____	_____	_____
First Witness Full Name	Title	Pager	Signature	Date & Time
_____	_____		_____	_____
Second Witness (required if by phone)	Title		Signature	Date & Time

ADDITIONAL INFORMATION

Attending Physician (Print full name):_____ Service: _____

Referring Physician (Print full name):_____

Date and Time of Death: _____

Location at Time of Death: ☐ UVMMC ☐ Other: _____

Chief Clinical Diagnoses: _____