CONSENT FOR PERINATAL POST MORTEM EXAMINATION

Registered Birth
(Baby shows signs of life at birth, regardless of gestation or does not show signs of life at birth and is at least 20 weeks gestation or weighs at least 400g at birth)

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: ____

(AFFIX MOTHER'S LABEL)

Interpreter required: Yes/No

If Yes, Language:

Interpreter's Name (print):

Date:

Interpreter's translation provided via phone or in person:

UR number: _____

Surname: _____

Given name/s: _____

Date of Birth: _____ Gender: ___

(AFFIX BABY'S LABEL)

The following checklist is provided to ensure that you have received adequate information.

The post mortem will only proceed if YES has been answered to all questions

- I understand the options and reasons for performing the post mortem ☐ Yes ☐ No
- I have received and/or read information about the options of post mortem ☐ Yes ☐ No
- I have received satisfactory answers to my questions ☐ Yes ☐ No
- I understand that as part of a thorough post mortem examination, sometimes specific organs may need to be temporarily kept for further testing which may delay the burial or cremation ☐ Yes ☐ No
- I understand that full and limited post-mortems involve taking and keeping small tissue samples and bodily fluids for testing and by law must be kept for at least 25 years ☐ Yes ☐ No
- I understand that the tissue samples taken may be used by researchers; however tissue samples cannot be used without approval by the hospital's Ethics Committee ☐ Yes ☐ No
- I understand that no whole organs will be kept by the hospital without my consent ☐ Yes ☐ No

Decision regarding Post Mortem examination (please tick one box)

(Full, limited and external examinations may include imaging and clinical photography that assist in assessment of physical abnormalities)

☐ I consent to a Full Post Mortem examination

☐ I consent to a Limited Post Mortem examination
Limited to examining (please specify organs/tissues/genetic testing/cell culture)

_____

_____

☐ I consent to an External Post Mortem examination (this may include imaging and clinical photography that may assist in assessment of physical abnormalities)

☐ **I do not consent** to any type of Post Mortem examination

Decision regarding retained tissue/organs during a post mortem examination

Whilst in the majority of cases, only small tissue samples are retained for testing, occasionally specific organs that need to be temporarily kept for further testing are unable to be returned prior to release to the funeral providers. In this instance, please indicate what you would like the hospital to do when the examination is completed (please tick one box)

☐ The hospital is to make arrangements for the lawful cremation or disposal of the organs

☐ The hospital may retain the organs for teaching and ethically approved research purposes

Identification of parent/legal guardian being requested to make a decision regarding post mortem examination (only one signature is required)

I have received sufficient information to give informed consent and have been given adequate time to make the decision	**I have received sufficient information to give informed consent and have been given adequate time to make the decision**
Parent/legal guardian name granting consent:	Parent/legal guardian name granting consent:
Relationship to baby:	Relationship to baby:
Signature:	Signature:
Date:	Date:

Witness Statement:

I have explained the nature and extent of the post mortem examination and believe that the parent/legal guardian making the decision has understood the explanation

I have provided a copy of this form to the parent/legal guardian

Doctor's Name (Print):_____Doctor's Signature:_____ Date:__/__/__

I request that a copy of the post-mortem report be provided to

Doctor:_____

Address:_____

Please provide original consent form to VPAS Anatomical Pathology and a copy to be filed in medical records

Clinical Information Form **Before Commencement of Post Mortem Examination** **(for referring clinicians)**	UR number:_____ Surname: _____ Given name/s: _____ Date of birth:_____ Gender: _____ (AFFIX PATIENT LABEL)

Please clarify what clinical questions need to be answered by the post mortem examination:

-
-
-
-

Ancillary investigations require a separate request slip.

Copy for report to Unit/Doctor	
Name:	**Time and Date of delivery:**
Duration of pregnancy at delivery:	**Stillborn Est'd time from death to delivery:** **OR** **Liveborn: post natal survival (m/h/d):**
Time and date of death: **____:-___(24 hour clock) ____/____/____ (DD/MM/YY)**	**Birth Weight (recorded on death certificate)**
Place of Delivery/Death (Hospital/Ward/Unit/Location):	
Maternal History	
Maternal medical history (including diabetes mellitus, hypertension, medications, etc)	
Maternal past obstetric history (including brief summary of course and outcome of previous pregnancies); parity (gravid, para)	
Present pregnancy LNMP EDD (Dates) EDD (Ultrasound – if different)	Multiple pregnancy Chorionicity (if known): Complications:
Antenatal screen: Blood group & Rh Maternal serum screen TORCH screen Hepatitis B&C Syphilis HIV	Other maternal investigations: Kleihauer test Auto antibodies Coagulation profile Group B Strep. Parvovirus
Other antenatal investigations/procedures: Ultrasound(s) findings (including abnormal/normal anatomy, placenta); Amniocentesis/chorionic villus sampling (FISH/Karyotyping); Fetal surgery	**Please include copies of reports**
Antenatal course (including premature rupture of membranes, bleeding, fever, hypertension, etc)	

Labour: Spontaneous/induced Duration Complications	
Delivery: Mode (vaginal, emergency/elective caesarean section – indication) Presentation Rupture of membranes Liquor (including meconium)	
Fetus: Liveborn/stillborn APGARS	
Neonatal course (if liveborn): Resuscitation Neonatal problems Investigative and therapeutic procedures	
Please continue writing if necessary. **Signature:** **Designation:** **Date:**	

Clinical Information Form – Before Commencement of Placental Pathology (for referring clinicians)

UR number: _____

Surname: _____

Given name/s: _____

Date of birth: _____ Gender: _____

(AFFIX PATIENT LABEL)

Please fill this form and include a signed placenta pathology request form

Consultant/Team:	Copies to:

Indication for request:
Gestation:

Relevant clinical History	
	Please State Yes (Y) or No (N)
Perinatal Death	
Post-mortem	
Surface subchorionic swabs taken for cultures	
Karyotype performed	
Preterm infant (<34/40 weeks)	
Prolonged rupture of membranes (>24hrs)	
Suspected maternal/fetal bacterial or viral infection	
IUGR	
Pre-eclampsia	
Essential hypertension	
Diabetes	
Placenta praevia	
Multiple pregnancy	
Type of multiple pregnancy	
Unexplained bleeding/clinical abruption	
Fetal anomaly	
Other relevant clinical history	
Relevant factors at time of labour/birth	

Signature :	**Print Name:**
Designation:	
Date:	

TRANSPORT AUTHORIZATION FORM

To: **Fax No:**

From: **Contact No:**

CC:

Date: **Number of pages including cover page:**

Re: **TRANSPORT AUTHORIZATION FROM ANATOMICAL PATHOLOGY**

The following information is intended for the addressee only and is CONFIDENTIAL.

The parents authorize baby _____ can be released into the care of Funeral Providers _____, for the purposes of transportation

SIGNED BY PARENT/LEGAL GAURDIAN: _____

Name of Parent/Legal Guardian: _____

Date: _____/_____/_____

FUNERAL DIRECTORS: _____

Address: _____

Contact Details:

Phone:_____ Fax:_____

GARMENTS AND MEMENTOES

I/we have provided garments and mementoes: ☐ No
☐ Yes. List items _____

_____