CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA

AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

CONSENT OR REFUSAL OF AUTOPSY

Regarding the body or pregnancy loss of:

NAME

PLACE OF DEATH

DATE OF DEATH

Consent of Autopsy

I have been informed about the nature and purpose of the autopsy and I understand that my child will be treated with dignity and respect. My questions are answered satisfactorily. I understand that devices or implants removed become the property of the hospital.

I understand that a complete autopsy involves a thorough examination of the body. This includes detailed external examination which may include photographs or diagnostic imaging, internal examination of all major body cavities, removal and examination of all organs. Fluid and tissue samples may be collected and retained for further examination and testing. The majority of the tissues examined are returned to the body on completion of the autopsy. However, due to the need to retain the brain, and on rare occasions other organs, for proper detailed examination, these organs may remain separate from the body and are disposed of by the hospital. Consenting to a complete autopsy or an autopsy limited to a specific body region includes consenting to this practice.

- I consent to a ***complete*** autopsy. ☐ **Initials**
- I wish to ***limit*** the examination to a specific body region or organ(s) even though this may reduce the diagnostic value of the autopsy as a source of information and answers (check box and initial):

☐ head ☐ chest ☐ abdomen ☐ chest and abdomen

☐ external examination only ☐ Other *(specify)*______________________

☐ **Initials:** _______________

Refusal of Autopsy:

I am aware this refusal may limit the available information about the cause of death.

I do **not** give consent for **any type** of autopsy. ☐ **Initials** ___

SIGNATURE OF PATIENT/ LEGAL GUARDIAN OR REPRESENTATIVE | DATE SIGNED

PRINT NAME | RELATIONSHIP

WITNESS - SIGNATURE OF PHYSICIAN, MIDWIFE OR DELEGATE | PRINT NAME - PHYSICIAN, MIDWIFE, DELEGATE

2ND WITNESS – (REQUIRED FOR CONSENT BY TELEPHONE ONLY) | PRINT NAME - PHYSICIAN, MIDWIFE, DELEGATE

STATEMENT BY INTERPRETER COMPLETE **ONLY** IF A PROFESSIONAL INTERPRETER IS USED TO OBTAIN CONSENT. I have translated the above information to the: ☐ patient ☐ parent ☐ legal guardian or representative and I have interpreted their responses to the health care professional.

SIGNATURE OF INTERPRETER | PRINT NAME OF INTERPRETER | DATE SIGNED