THE University of Vermont MEDICAL CENTER

Deceased Full Name:
Date of Birth
MRN:

Pathology & Laboratory Medicine (802-847-3570)

CONSENT FOR AUTOPSY

The autopsy (post-mortem examination) 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 examination 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 autopsy.

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 remain anonymous. I have been given the opportunity to ask any questions that I may have regarding the scope or purpose of the procedure.

I GRANT PERMISSION TO THE UNIVERSITY OF VERMONT MEDICAL CENTER (PHYSICIANS 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 handled in accordance with the law.

I AUTHORIZE:

- ☐ Complete Autopsy
- ☐ *Restricted* Autopsy with the following restrictions :_____

_____

Legal next-of-kin of the deceased (order of legal next of kin = spouse > adult child > parent > adult sibling)

_____	_____	_____	_____
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 (physician)	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: _____