Authorization for Performance of ALTRU Autopsy

Patient Name: ______________________ MRN#: ______________________ Date: ______________________ Physician Requesting Autopsy: ______________	Stamp plate:

The autopsy is a medical and scientific procedure, intended to establish the cause of death, and to determine the scientific reasons for that death. Each autopsy contributes to our knowledge and understanding of medicine and may benefit persons still alive. Thus, the autopsy allows someone who has died to continue to contribute to mankind, even after death.

The procedure necessarily will require surgical incisions to allow observation and removal of organs, but no visible disfigurement of the clothed body is expected. Organs, tissues, and other specimens may be retained for future study. Some conditions, including but not limited to, non-atherosclerotic cardiac disease, occupational lung diseases and neurologic disorders typically require organ retention and prolonged study or consultation for diagnosis. Any retained tissue / organs may be disposed of in a manner that other medical tissue is disposed of in accordance with local and hospital regulations.

I (We), (name[s]) ______________________________________, the legal next-of-kin of ________________, am (are) the closest living relative(s), and entitled by law to control the disposition of the remains; I (we) hereby authorize and request UND Pathology to perform an autopsy on the body of said deceased at UND Forensic Pathology Center, for the purpose of determining the cause of death and for the better understanding of those other conditions that may have contributed to death. I (We) agree to the removal and retention of prosthetic devices and those organs, tissues, and specimens from the autopsy as the pathologists and physicians deem proper, and the use of these materials for diagnosis, education, research, and other scientific purposes, and to their eventual disposition by the hospital. This consent does not extend to removal or use of tissue, devices or organs for transplantation.

I (We) understand that the pathologists may request additional medical records for performance of the autopsy and will authorized such release. I (We) understand that a complete report will be sent to the individuals authorizing the autopsy or designee and on request to other next-of kin, to the deceased's physician / health provider, coroner/medical examiner or law enforcement agency authorized with investigating the death or tissue procurement agencies if family has authorized tissue recovery. I (We) understand that the autopsy report will become part of the deceased medical records and will be subject to applicable disclosure laws. North Dakota law NDCC (11-19.1-07) requires all physicians to report deaths resulting from criminal or violent means, suspicious or unusual manners or resulting from reportable circumstances.

I (We) understand that we may place limitations on both the extent of the autopsy and retention of organs, tissues and devices. I (We) understand that any limitations may compromise the diagnostic value of the autopsy and may limit the usefulness of the autopsy for education, quality improvement and the answers desired by family and/or health care providers. I have been given the opportunity to ask questions regarding the scope or purpose of the autopsy.

Limitations: ☐ NONE: Permission is granted for a complete autopsy, with removal, examination and retention of material as the pathologists deem proper for purposes set forth above and for disposition of such material as the pathologist or hospital determines.

☐ LIMITATIONS: Permission is granted with the following restrictions:______________________________

Areas / concerns / reasons the family/next of kin are particularly interested in:______________________________

I (We) have read the above, have had the opportunity to discuss it, and understand it.

______________________________ Signature of relative authorizing the autopsy	______________________________ Relationship(s) to deceased
______________________________ Signature of person requesting autopsy	______________________________ Printed name of person requesting autopsy
______________________________ Signature of Witness	______________________________ Printed Name of Witness

______________ Date ______________ Time

☐ Check if permission obtained by telephone. The above statements were read by the person obtaining permission. There was opportunity to ask questions and the person below affirms that consent was given :

______________________________ Signature of witness to telephone permission	______________________________ Printed name of witness to telephone permission