AUTHORIZATION FOR AUTOPSY PAYMENT

(For autopsy referral to Seattle Children's Hospital)

NOTE: All cases must be discussed with and approved by the On-call SCH pathologist before this form is completed. A faxed copy of the completed form must be on file at SCH before the patient is transported.

Paging operator: 206-987-2131

Department of Laboratories (FAX): 206-987-3840

Referring Institution: _____

Referring Physician: _____

SCH Pathologist with whom case was discussed:_____

Date: _____

This document serves as attestation that the above named institution will be responsible for payment to Seattle Children's Hospital for the autopsy performed on the fetus/infant/child of

_____ who died on _____.
(Mother's name) (Date)

Representative of responsible party: _____

Title/Position: _____