NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

PATIENT IDENTIFICATION

AUTOPSY CONSENT

I, (print name) _____ , the (relationship to the deceased) _____ of the deceased, grant permission to Nationwide Children's Hospital to perform an autopsy upon the body of (print name of the deceased) _____ .

I authorize the removal, examination, and retention of specimens including tissue, organs (including the brain), fluids, and devices ("Autopsy Specimens") for diagnostic, education, quality improvement, and/or research purposes. I understand that I can choose to place limitations on the extent of the autopsy and the future use of Autopsy Specimens. I understand that any limitations I place on the autopsy may affect the diagnostic value of the autopsy and may limit the usefulness of the autopsy for education, quality improvement, and/or research purposes. I understand that any diagnostic information gained from the autopsy will become part of the deceased's medical record. I also understand that this consent does not extend to the removal or use of Autopsy Specimens for transplantation or similar purposes. I understand that after the autopsy, Autopsy Specimens that are not needed for diagnostic, quality improvement, educational, and/or research purposes will be sent to the funeral home or disposed of appropriately under the pathologist's direction.

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

Initial Only One Box:

☐ **Autopsy With No Limitations.** I permit a standard autopsy that includes all organs, as described above.

☐ **Autopsy With Limitations**. I permit an autopsy with the following limitations (complete only applicable areas below):

1. I permit an autopsy of only the following (state regions of the body or organs; for example, "heart and lung only" or "brain only"): _____
2. I request that after samples are taken, the following organs are returned to the body at the time of autopsy. I understand that returning the organs results in less opportunity to obtain information: _____
3. By initialing here, I do not grant permission to retain and use Autopsy Specimens for research purposes: _____
4. I also have the following limitations/requests: _____

_____ Date: ____/_____/_____ Time: _____ [ ] a.m. [ ] p.m.
Signature of parent / legal guardian MM DD YYYY

_____ _____
Signature of person obtaining permission | Printed name of person obtaining permission

_____ _____
Signature of witness | Printed name of witness

_____ ( ) _____
Printed name of responsible physician * | Pager or cell phone number of responsible physician

** Complete only if responsible physician is not the person obtaining permission.*