IWK Health
Anatomical Pathology Laboratory
3rd floor, 5850 University Avenue
Halifax NS B3K 6R8
Phone: (902) 470-8285
Fax: (902) 470-8989

Consent for Post-Mortem Examinations (Autopsy)

I, _____, the _____ of the deceased,
(Full name of person giving consent) *(Relationship to Deceased)*

being allowed by law to consent, hereby allow the Pathologists of IWK Health to perform the specified post-mortem examination(s) (autopsy) upon the remains of:_____
(Full name of deceased)

The post-mortem examination procedure(s) have been explained to me by _____
(Provider Obtaining Consent)

in terms that I fully understand. I have been given an opportunity to read the **Information for Families About Post-Mortem Examinations & Autopsy** and have received answers to any questions. I may withdraw or change this consent at any point before the examinations have taken place

☐ **Complete Post-Mortem Examination:**	☐ **General Post-Mortem Examination; no retention of whole organs:**	☐ **External Only Post-Mortem Examination:**
I consent to an unrestricted examination, which may include external examination, radiology, internal examination including tissue sampling, genetic testing, and retention & storage of whole organs that require detailed examination (Note: this option is required for brain & spinal cord examination).	I consent to a post-mortem examination which may include all of the elements described for complete examination, except retention & storage of whole organs. (Note: this option prevents proper brain & spinal cord examination).	I consent to only external examinations and radiologic examinations of the body.

❑ **Directed examination / other Instructions:** Provide specifics of consent or refusal for specific investigations.

_____

_____

_____

_____

_____

The preliminary and final reports of these examinations will be sent to _____
(attending/most responsible provider)

who has been notified that they are responsible for explaining the results to me.

Additional copies of reports to be sent to Dr(s): _____

_____	_____	_____
Time (24 hour clock)	*Date (yyyy/MON/dd)*	*Print name and signature of **person giving consent (next of kin, substitute decisionmaker)***
_____	_____	_____
Time (24 hour clock)	*Date (yyyy/MON/dd)*	*Print name, designation and signature of **provider obtaining consent***

Signature of second witness (required for telephone / verbal consent): _____

_____	_____	_____
Time (24 hour clock)	Date (yyyy/MON/dd)	(Print name and signature of pathologist reviewing terms of consent)

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Consultation for Post-Mortem Examinations (Autopsy)

To: Pathologist

Clinical history / Reason for post-mortem examination / Questions to be addressed:

Indicate specific or special testing/examinations requested (within limits of consent):

Post-mortem imaging:

- ❑ Routine or as deemed appropriate by pathologist.
- ❑ Other (please specify requested examinations & indications; please note availability depends on capacity of Department of Diagnostic Imaging and approval of radiologist:

Genetic testing:

- ❑ Routine aneuploidy testing +/- microarray per Clinical Genomics guidelines (fetal/stillbirth samples).
- ❑ Other (please specify requested tests & indications; please note whether Medical Genetics has already been consulted or should be consulted:

If you have questions about post-mortem examinations, the consent process, or this form , please contact the IWK Pathologist on-call for autopsies, via the IWK Switchboard at 902-470-8888.

Time (24 hour clock) _____ Date (yyyy/MON/dd) _____ (Print name and signature of provider requesting examination (required) _____

Pager/cell number if questions arise about Consent or Consultation request (required): _____