IWK Health

Disposition of Remains

I, _____, hereby request IWK Health to release the
Print name of consent giver

remains of _____ . (Choose one option below and sign)
Print name of deceased

Option 1: ❑ Release remains to funeral home _____ _____
Name of Funeral Home Initials of consent giver

_____ _____
Area code and phone number of funeral home Area code and fax number of funeral home

I, _____ , acknowledge that I am responsible for all contact and follow-up with the funeral home listed above regarding all arrangements and requested services. _____
Initials of consent giver

Option 2: ❑ Release remains to me, my designated family member, or individual (For use in situations where family wishes to transport the remains from the Health Centre to the funeral home).

_____
Initials of consent giver

_____ _____
Print name of patient, designated family member of individual Relationship to consent giver

CHOOSE OPTION 1 OR 2 ABOVE and then complete this section:

Time (24 hr clock)	Date (yyyy/mon/dd)	Print Name/Consent Giver	Signature of Consent Giver

Time (24 hr clock)	Date (yyyy/mon/dd)	Print Name and Professional Designation	Signature of Witness

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All remains sent to IWK Health will be sent back to the Referral Centre upon completion of the autopsy. Please fill out Referral Centre name, contact personnel, and phone number.

❑ Completed by Referral Center only

Referral Centre name: _____

Contact personnel: _____

Phone number _____

MUST COMPLETE THIS BOTTOM SECTION WITH SIGNATURE OF PROFESSIONAL (RN OR ATTENDING) ONLY WHEN THE FOLLOWING CONDITION OCCURS: Less than 20 weeks gestation *AND* less than 500 grams *AND* no signs of life at birth.

I certify _____ can be released without the Vital Statistics Forms: Medical
Name of Mother
Certificate of Death, Registration of Death and/or Registration of Stillbirth as the above requirements are met (less than 20 weeks gestation ***AND*** less than 500 grams ***AND*** no signs of life at birth).

Time (24 hr clock)	Date (yyyy/mon/dd)	Print Name and Professional Designation	Signature of RN or Attending Physician