IWK Health Centre

Disposition of Remains

I, _____, hereby request the IWK Health Centre 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 (dd/mm/yyyy)	Print Name/Consent Giver	Signature of Consent Giver

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

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DECLINE OPTIONS 1 and 2 ABOVE then complete this section:

In rare circumstances, for early pregnancy loss or early newborn loss where consent giver declines options 1 and 2 above:

I, _____, do not choose either option 1 or 2 above. I give consent for the IWK to cremate and inter (bury) the cremains (ashes). I understand that no further contact will take place with me regarding the cremains (ashes).

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

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

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❑ Completed by Referral Center only _____
Name of Referral Center

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 (dd/mm/yyyy)	Print Name and Professional Designation	Signature of RN or Attending Physician