

Appendix C



HENRY FORD HEALTH SYSTEM
AUTOPSY PERMIT AND CONSULTATION FORM
Originating Hospital Henry Ford Allegiance Hospital

MRN
DOB
ADM

Date: _____ Time: _____ Accession Number: _____

I, _____ state that my relationship to the above deceased is:
 parent spouse sibling next-of-kin person charged by law with the responsibility for disposition of the body
other, and I hereby certify that I assume custody of the body of the deceased.

I decline Autopsy: (signature) _____ Date _____ Time _____

I, _____ hereby authorize Henry Ford Health System physicians and their representatives to conduct an autopsy in the interests of determining the cause of death and nature and extent of disease; and the removal and preservation of such organs, and parts of organs and tissues as may be believed proper for the advancement of medical knowledge, progress, and/or treatment of other patients.

Select one of the following items for authorization:

- Complete Autopsy: Chest, abdominal and cranial (head) cavity contents
- Complete Autopsy, excluding brain
- Limited Autopsy: Contents of specified body cavity(s) only. Circle all appropriate selection(s) head, chest, abdomen
- Restricted –examination and removal of these specified organ(s): _____
- Other Modification(s) for any changes to autopsy (permission is requested): _____
- Special examination of areas not usually examined by autopsy including: i.e. surgical sites _____

I, _____ hereby authorize the autopsy of the deceased person to be completed at Henry Ford Allegiance Hospital Campus.

Authorizing Signature _____ Relationship _____ Date/Time _____

Physician Signature _____ Pager/Cellular # _____ Date/Time _____

Witness Signature _____ Date/Time _____

SECTION BELOW MUST BE COMPLETED BY THE "TREATING PHYSICIAN" BEFORE THE AUTOPSY CAN BEGIN:

Hazardous Materials/Risk:	Medical Examiner Notification:

Principal Diagnosis: _____

Summary of Clinical Course (please include supportive tests and imaging studies): _____

Specific Questions to be answered by Autopsy: _____

Treating Physician(s) to be called: (PRINT) _____ Phone/pager _____

Send additional reports to: _____

Pathologist: _____ (NOTE: Both Preliminary and Final Autopsy reports will be available in the EHR)