

Patient Name: _____

Date of Birth: _____

MRN: _____

Early Pregnancy Loss Form

This is an agreement between myself and Henry Ford Health (HFH) about how fetal remains will be treated in an ethical way. By signing this form, I understand and agree to all the information below.

Henry Ford Health agrees that:

- Michigan Public Health Code requires that we handle fetal remains in a specific way.
- We will contact you if any fetal remains are found in the pathological exam. We will get your permission for the dignified disposition of these remains.

I understand and agree that:

- I was told the meaning of 'fetal remains' (placenta, umbilical cord, or clots from pregnancy loss **are not included**).
- When HFH contacts me, I may tell them a funeral home or cemetery that I would like the fetal remains privately cremated or buried at.
 - I know I am responsible for these arrangements and costs.
 - I know there may be more paperwork I need to fill out at the hospital if I choose this.
 - I know that if I am married, my partner will need to sign the paperwork as well.
- I may choose to have HFH provide a respectful cremation or burial of the fetal remains.
 - I know I cannot retrieve any fetal remains after the hospital provides cremation or burial.
 - I know that I am not responsible for these arrangements or cost.
 - I know there may be more paperwork I need to fill out at the hospital if I choose this.
 - I know that if I am married, my partner will need to sign the paperwork as well.
- If HFH is not able to contact me within 30 days of the first attempt (by phone or by letter), I authorize (allow) HFH to have the fetal remains cremated or buried in a respectful way. These will be considered unclaimed fetal remains.
- My phone number and address are correct on this form and in my medical record.
- I agree to waive and forever release HFH, its officers, agents, and employees from and against any and all claims, causes of actions and liabilities, related to the hospital providing final disposition of my fetal remains by cremation or burial.
- I was given a copy of this form and know it can only be changed if written on and signed by an authorized representative of HFH.

Fill out your contact information **before** you sign the form. This ensures HFH can get in touch with you.

Patient Name Printed

Patient Phone Number

Patient Address (Street, City, State, Zip Code)

Patient Signature

Date

Time

Signature of Patient's Married Partner (if applicable)

HFH Employee Witness Signature

HFH Employee Witness Name Printed