

**CONSENT FOR POST MORTEM EXAMINATION (MR 102)**

Med Rec. No: .....  
Surname: .....  
Forename: .....  
Sex:..... D.O.B. ....

AFFIX LABEL HERE

**Part A WRITTEN CONSENT FROM NEXT OF KIN**

I \_\_\_\_\_ hereby give my consent for a post mortem examination to be performed on \_\_\_\_\_ subject to the conditions specified below.

The following checklist is provided for you to ensure that you have received adequate information.

We will only proceed if YES is ticked in all boxes.

- I have read and understood the Post Mortem Information Pamphlet. YES  NO
- I have had the opportunity to ask questions. YES  NO
- I have received satisfactory answers to all my questions. YES  NO
- I understand that no whole organs will be retained without my consent. YES  NO
- I understand that tissue samples or fluids will be taken and held for laboratory investigations. YES  NO
- I understand that other health professionals (e.g. pathologists in training, medical practitioners, nurses) may be present at the post-mortem in addition to the pathologist undertaking the examination YES  NO
- I understand that medical photographs may be taken at the time of the post mortem. YES  NO
- I understand that routine tissue samples will be taken for Histology and retained indefinitely and that these samples may be used for teaching and quality control. YES  NO
- I have received sufficient information to give informed consent and been given adequate time to make the decision. YES  NO

**Consent for the following Post Mortem Examination has been given**

(Please tick ONE box and state limitations if necessary)

- Full Examination  Limited Examination
- Step-Wise Examination  External Examination Only

**Consent for the Retention of Whole Organs**

Apart from routine samples taken for Histology, whole organ(s) can be retained for further investigation if necessary to fully understand the cause of death and effects of treatment.  Yes  No

If whole organ(s) may be retained specify which: \_\_\_\_\_

**Method of Organ Disposal after Examination**

After further investigation of the organ(s) retained is complete, those organs must be disposed of in a lawful way. Your options are

- 1. The hospital may dispose of the organs in a lawful and respectful way.  Yes  No
- 2. I will arrange for the organs to be disposed of in a lawful way.  Yes  No
- 3. I wish the organs to be reunited with the body before it is released even though this may delay the funeral.  Yes  No

**My relationship to the deceased is:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Part B** Witness certifying that all relevant information has been provided to the next of kin signing above:

Print Name and title: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**OR Part C VERBAL CONSENT FROM NEXT OF KIN (Medical Officer to Complete)**

Verbal consent has been obtained from \_\_\_\_\_ the senior available next of kin of \_\_\_\_\_ (baby/child's name) for a post mortem examination to be performed .

**Declaration: I have discussed with the aforementioned next of kin all points raised in Part A of this form, and have indicated where required their conditions of consent (by proxy).**

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Part D POST MORTEM RESULTS**

1. I would like a brief report in plain language to be sent to me via -

Dr \_\_\_\_\_

Address \_\_\_\_\_

**NOTE:** Technical and Plain Language Reports cannot be sent directly to parents.

2. I would like the full technical report to be sent to –

Dr \_\_\_\_\_

Address \_\_\_\_\_

The name of a GP or other Doctor must be provided.

**Part E POST MORTEM COORDINATOR (PMC)**

All relevant documentation has been provided to the parents and informed consent has been obtained to the best of my knowledge.

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

The next of kin were contacted by:

Phone: Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

Visit: Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time: \_\_\_\_\_

**Part F AUTHORITY FOR POST MORTEM EXAMINATION (NOT to be completed by requesting doctor)**

I \_\_\_\_\_

having the powers of a designated officer delegate to me under the Human Tissue Act 1982, authorise a post mortem examination to be performed on the above named deceased.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Part G - CLINICAL INFORMATION TO BE COMPLETED BY THE REQUESTING DOCTOR ONLY**

**PAST HISTORY AND OTHER RELEVANT MEDICAL DETAILS including infectious risks:**

**WHAT SPECIFIC QUESTIONS WOULD YOU (AS THE REQUESTING DOCTOR) LIKE TO GAIN ANSWERS TO FROM THIS POST MORTEM EXAMINATION?**

***THIS SECTION TO BE COMPLETED FOR NEONATAL DEATHS ONLY***

**LABOUR and DELIVERY**                      Onset: Spontaneous / Induced

**PRESENTATION**                              Method: Spontaneous / Forceps / Caesarean

**Date & Time of Delivery** \_\_\_\_ / \_\_\_\_ / \_\_\_\_                      AM / PM

**BABY - SEX - M / F**    Apgars:                      INTUBATED: YES/NO                      BIRTH WEIGHT \_\_\_\_g

**NEONATAL PROBLEMS -**

All procedures carried out on infant (include details of ventilatory support and duration)

**DEATH**    Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_    Time \_\_\_\_    Duration of Extrauterine Life \_\_\_\_

**The following Clinicians wish to attend the Post Mortem Examination**                      (PLEASE PRINT)

**1. Dr:** \_\_\_\_\_                      **Pager No.** \_\_\_\_\_

**2. Dr:** \_\_\_\_\_                      **Pager No.** \_\_\_\_\_

**TO BE COMPLETED BY POST MORTEM COORDINATOR or DELEGATE**

**NEXT OF KIN DETAILS**

**SURNAME:** \_\_\_\_\_ **GIVEN NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**MEDICAL OFFICER (S):** \_\_\_\_\_

**DECEASED DETAILS**

**UMRN:** \_\_\_\_\_

**SURNAME:** \_\_\_\_\_ **GIVEN NAME:** \_\_\_\_\_

**SEX:** M F **AGE:** \_\_\_\_\_

**DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **DOD:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**DOCUMENTATION RECEIVED**

- BDM201 – MEDICAL CERTIFICATE OF CAUSE OF STILL BIRTH OR NEONATAL DEATH
- RG 356 – MEDICAL CERTIFICATE OF CAUSE OF DEATH
- FORM 7 – CERTIFICATE OF MEDICAL ATTENDANT
- MR 102 – CONSENT FOR POST MORTEM EXAMINATION

**POST MORTEM DISCUSSION DETAILS and CHECKLIST**

**PM CO-ORDINATOR** \_\_\_\_\_

**PRESENT** \_\_\_\_\_

**RELATIONSHIP TO DECEASED** \_\_\_\_\_

**INFORMATION PAMPHLET**     PROVIDED     READ     DISCUSSED

**ISSUES DISCUSSED**

- PM INCISIONS**
- PM OPTIONS**                      Full / Limited /                      External / Step-By-Step / Other
- ROUTINE TISSUE SAMPLES** - taken at post mortem for Histology and retained indefinitely
- RETENTION OF TISSUE / ORGANS**
- PM REPORTS** Plain Language Report / Technical Reports Preliminary and Final Reports
- VALUE OF A POST-MORTEM EXAMINATION**

**QUESTIONS RAISED BY NEXT OF KIN**     YES     NO

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ANSWERS GIVEN**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**POST MORTEM COORDINATOR**

**SIGN** \_\_\_\_\_ **DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NEXT OF KIN**

**SIGN** \_\_\_\_\_ **DATE** \_\_\_\_ / \_\_\_\_ / \_\_\_\_