Informed Consent for
Fetal or Neonatal Autopsy

To be used for fetal deaths 20 0/7 weeks of gestation and greater or any death after live birth.

Facility:

☐ Fairview Lakes Medical Center
☐ Fairview Northland Medical Center
☐ Fairview Range Medical Center
☐ Fairview Ridges Hospital
☐ Fairview Southdale Hospital
☐ University of Minnesota Medical Center

To be completed by the Provider (choose one):

☐ External (gross only): automatically performed, no consent required
☐ Internal (complete): not automatically performed; consent required

Reason for the autopsy: _______________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Provider (printed name) Provider signature Date Time

Provider pager and/or cell phone (required): ____________________________

To be completed by authorized decision maker:

I have read this entire form (including consent on back) and my questions have been answered. I understand the information I have been given. I agree to the autopsy. If I have special instructions, I have given them to the doctor, and the doctor has noted them above.

Signature of authorized decision-maker Date Time

Print name of authorized decision-maker Relationship to deceased

To be completed by person(s) witnessing or verifying the authorized decision-maker’s signature.

Initial one of the two options below and then sign the signature line.

I have witnessed the signature of the authorized decision-maker. ______ (initial) Or:
I have heard the telephone consent of the authorized decision-maker. ______ (initial) ______ (initial)

Witness signature Print Witness Name Date Time

2nd witness signature (phone consent only) Print Witness Name Date Time

Interpreter name (if used) Language/Organization Date Time
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I've talked with the doctor about the autopsy. I've been told:

- That my baby will be treated with dignity and respect during the exam.
- These exams may be external or internal.
- Some lab tests require an internal exam to obtain test samples.
- Examiners may need to identify and remove parts of the body for viewing and testing.
- Internal exams sometimes discover why my baby died and sometimes find problems that may affect the mother’s current or future health and her ability to sustain a future pregnancy.
- I can ask for the exam to be external only. The examiner records weight, measurement and any developmental abnormalities seen. Radiological studies may be done if needed.
- The results of the exam will be sent to the doctors involved in my care and the care of my baby.

I agree:

To allow my blood to be tested for HIV and hepatitis, if another person is exposed to my or my baby’s blood or body fluids. The sooner testing is done, the sooner treatment can be started if it is needed. By law, the test results will go to:

- The doctor and into the medical record.
- Fairview Employee Occupational Health Services, if the person exposed is a health care worker.
- Infection Prevention at this hospital for reporting to state health officials, if relevant.

I understand that:

- Tissues or organs removed for examining and testing may be used for research or teaching purposes after the autopsy exam is complete. These leftover tissues will not be labeled with my baby’s name or other information that would identify my baby.
- Tissues and organs will not be sold. Tissues and organs will be disposed of with respect.
- Students and other people approved by the hospital may watch the exam.
- This consent does not include donation of any body parts for transplanting in humans.
- This consent does not specify how I want the remains to be handled (funeral home or hospital disposition when eligible).