

NEW YORK-PRESBYTERIAN HOSPITAL
New York Columbia University Medical Center



AUTOPSY CONSENT FORM

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

(NO TELEPHONE CONSENT ACCEPTED)

Date: _____

Date/Time of Death: _____

I, the legal next of kin, authorize an **AUTOPSY** for purpose of **ASCERTAINING THE CAUSE OF DEATH AND FURTHERING MEDICAL KNOWLEDGE**. I further authorize the examination, retention, and disposal of such organs and/or tissues as the **NEW YORK PRESBYTERIAN HOSPITAL – COLUMBIA UNIVERSITY MEDICAL CENTER** in the City of New York considers necessary or appropriate for such purposes.

RESTRICTIONS: NONE EXCLUDE HEAD HEAD ONLY

OTHER: _____

OTHER SPECIFICATIONS: _____

Print Name

Signature

Relationship

****ME CASE:** YES NO

ME CASE #: _____

ME CLINICIAN/INVESTIGATOR: _____

****NEWBORN/STILLBORN (Please initial where applicable)**

LIVE BORN STILLBORN FETUS _____ WKS **SEX:** MALE FEMALE

PVT BURIAL CITY BURIAL CREMATION HOSPITAL DISPOSAL

AUTHORIZED HOSPITAL REPRESENTATIVE:

PRINT NAME

SIGNATURE

CONTACT INFO/PAGER #

CLINICAL DIAGNOSIS: _____

*****INSTRUCTIONS FOR CONTACTING PATHOLOGY WHEN CONSENT IS COMPLETED:**

Once consent is granted, the clinician needs to page the 8-P-A-T-H (87284) beeper to inform the Pathology Dept. of the consent. The consent is then given to the Admitting Office or the Nursing Coordinator.

*****Note:** Consent must be obtained from the **NEXT OF KIN** in order of priority stated: (a) spouse, (b) child 18 years of age or older, (c) parent, (d) brother or sister (18 years of age or older), (e) guardian, (f) person authorized to dispose of body.