



UNIVERSITY OF IOWA HOSPITALS AND CLINICS
DEPARTMENT OF PATHOLOGY
200 Hawkins Dr., Iowa City, IA 52242

DATE OF REQUEST:
DECEDENT NAME:
DECEDENT BIRTH DATE:
DECEDENT ADDRESS:

USE PRE-PRINTED LABEL OR IMPRINT IF AVAILABLE, OTHERWISE, PLEASE PRINT CLEARLY

This area for use by UIHC staff only

UIHC AUTOPSY #:

Sex: Age:

Date of Death: date hour

Pronounced dead by: M.D./D.O. Print name:

Attending physician: M.D./D.O. Print name:

If inpatient: Hosp #: Service: Unit: Date of Admission: date hour

REQUEST FOR POSTMORTEM EXAMINATION (FETAL/PERINATAL/PEDIATRIC)

In order to verify the cause of death of (Hospital #: if applicable), and to aid in the diagnosis and treatment of persons suffering from complications similar to those from which the above deceased suffered, I hereby request and authorize that a postmortem examination be performed upon the body of the above deceased, the same to be made under the direction of a Pathologist on the staff of The University Hospitals, also that such organs and parts of the body may be removed and retained as the Pathologist considers desirable, for diagnostic, scientific research, educational, or therapeutic purposes. It is understood that there will be a charge for this examination.

Restrictions (state 'None' or specify):

date hour

Signature: Print name:

Relationship to decedent:

Address:

Permission obtained by (if applicable): M.D./D.O. Print name:

Funeral Home of family's choice:

Address of Funeral Home:

Autopsy report to be sent to (list family, physician, institution, etc.):

Name: Name: Name:

Address: Address: Address:

Phone: Phone: Phone:

Fax: Fax: Fax:

Released to FUNERAL DIRECTOR: (for use by UIHC staff only)

Firm Name: Address:

Signature of person taking remains: (license # if applicable)

Print name of person taking remains: Date/Time: date hour

REQUEST FOR POSTMORTEM EXAMINATION (FETAL/PERINATAL/PEDIATRIC) CONTINUED

Decedent name: _____ Hospital # (if applicable) _____

CLINICAL DIAGNOSIS AND SUGGESTIONS TO PATHOLOGIST (to be completed by the attending or requesting physician)

OBSTETRIC HISTORY:

Maternal age: _____ G ____ P ____ Gestational age: _____

Date of infant's birth: __ / __ / __ Date of infant's death: __ / __ / __ (if IUFD, give approximate duration)

Pregnancy: Uneventful:

Complications:

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Other relevant history:

ULTRASOUND FINDINGS:

GENETICS:

Seen by pediatric geneticist? Y N / genetic testing performed? Y N

Provide name of clinician: _____ phone #: _____

Summary of genetics report, if complete:

CHROMOSOME STUDIES: (please check as appropriate)

Chromosome studies not necessary: ____

Chromosome studies to be sent at autopsy: ____

Chromosome studies already sent ____, report pending: ____

Summary of chromosome report, if complete:

SKELETAL SURVEY:

Performed: Y N Summary of radiology report, if complete:

1. Describe the fundamental disease and its manifestations with minor or incidental conditions that also contributed. Describe the clinical course culminating in death.

2. Describe any particular clinical questions to be addressed by the postmortem examination.

3. For discussion before and after autopsy, provide name and contact information of attending physician who is most familiar with the clinical history.

Attending physician: _____ M.D./D.O.

Telephone #: _____ Fax #: _____ Pager or cell phone #: _____

Address: _____

Requesting physician signature: _____ **Date:** _____