NOT TO BE USED ON INPATIENT DEATHS

UNIVERSITY of IOWA HEALTH CARE

U I D L

U of I Diagnostic Laboratories

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

JOB#/DATE

H-4c

NOT TO BE USED ON INPATIENT DEATHS

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:** _____