For a **liveborn infant** and subsequent neonatal demise, **place infant patient label here.**

In the case of an **IUFD/fetal demise**, place both **maternal patient label and fetal lab specimen label at the top of this form.**

Release of Body to Funeral Home
(IUFD or Neonatal Demise)

Mother's Name: ____

Infant Name in Epic (if infant was liveborn): ____

Infant Name on birth/death certificate (required if infant was liveborn; optional for IUFD):

____

Infant Date of Birth/Delivery: ______________________________

I have selected the funeral home designated below to assist with final arrangements.

Funeral Home Name: ____

Funeral Home Address: ____

Funeral Home Phone Number: ____

Funeral Home Contact Person: ____

Printed name of parent/closest next of kin/legal guardian: ____

(Must be mother if not married, closest next of kin if mother not available, or if legal documents are present then legal guardian)

Relationship to Infant (if not Mother): ____

Signature of parent/closest next of kin/legal guardian:____

Date and Time: _____/_____/_______ ___________ ☐ AM ☐ PM

For a **liveborn infant** and subsequent neonatal demise, **place infant patient label here.**

In the case of an **IUFD/fetal demise**, place both **maternal patient label and fetal lab specimen label at the top of this form.**

Approval and Verification for Self-Transport of Body (IUFD or Neonatal Demise)

Mother's Name: ____

Infant Name in Epic (if infant was liveborn): ____

Infant Name on birth/death certificate (required if infant was liveborn; optional for IUFD):

____

Infant Date of Birth/Delivery: _____________________

I have selected the funeral home designated below to assist with final arrangements. **I will *SELF*-TRANSPORT** the infant's body to the funeral home.

Funeral Home Name: ____

Funeral Home Address: ____

Funeral Home Phone Number: ____

Funeral Home Contact Person who approved self-transport: _______________________________________

UAMS staff who verified funeral home approval: ____

Printed name of parent/closest next of kin/legal guardian transporting the body: ______________________________
(Must be mother if not married, closest next of kin if mother not available, or if legal documents are present then legal guardian)

Relationship to Infant (if not Mother): ____

Signature of parent/closest next of kin/
Legal guardian in receipt of body: _____________________________________ Date/Time: ___________________

UAMS staff releasing the body:

Printed name: _______________________________________

Signature: ____ Date/Time: ____________________

Witness (should be a charge Nurse, unit manager or ADON):

Printed name: _______________________________________

Signature: ____ Date/Time: ____________________

Date and Time of Release: _____/_____/_______ ___________ ☐AM ☐PM

The UAMS staff signing for release of the body and as a witness to said release verify that the following items have also been completed:

Copy of death certificate given to parent/closest next of kin/legal guardian and a copy placed in infant chart (if liveborn) or maternal chart (for IUFD).

ADH Transit Form VR-30 completed and given to parent/closest next of kin/legal guardian (this form must accompany the body) and a copy placed in the infant chart (if liveborn) or maternal chart (for IUFD).

For a **liveborn infant** and subsequent neonatal demise, **place infant patient label here.**

In the case of an **IUFD/fetal demise**, place both **maternal patient label and fetal lab specimen label at the top of this form.**

Request for UAMS Final Disposition of Body
(IUFD or Neonatal Demise)

Mother's Name: ____

Infant Name in Epic (if infant was liveborn): ____

Infant Name on birth/death certificate (required if infant was liveborn; optional for IUFD):

____

Infant Date of Birth/Delivery: _____________________________

I request that UAMS arrange for cremation of the body/products of conception.

I understand that by selecting this option, I will not receive the cremains.
UAMS will arrange for a final resting place.

Printed name of parent/closet next of kin/legal guardian: ____

(Must be mother if not married, closest next of kin if mother unavailable, or if legal documents are present then legal guardian)

Relationship to Infant (if not Mother): ____

Signature of parent/closest next of kin/legal guardian:____

Date and Time: _____/_____/_______ __________ ☐ AM ☐ PM

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

AUTOPSY STATUS

If autopsy is **refused**, complete **FORM A** of this form. If autopsy permission is **granted**, complete **FORM B** of this form.

FORM A

Autopsy permission refused [ ]

Release the remains of

____
(Name of deceased)

to:

______________________ ______________ ________
(Name of Undertaking Establishment) (City) (State)

Do not write below this line – for Pathology use only

BODY RECEIPT

I certify that the remains of the above-named patient, after proper identification, were received by me for the purpose of burial.

____
Signature

____
(Name of Undertaking Establishment)

____

____
Address

__________ __________
Date Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

AUTOPSY STATUS

Form B

Telephone Consent: [ ] Yes [ ] No

(See Department of Pathology Procedures Manual located at all nursing stations for appropriate procedure for obtaining telephone consent)

This form does NOT authorize the use of organs, tissues, or parts for transplantation.

If consulting for a fetal loss, fetal age is at least 20 weeks and/or fetus is at least 350 grams.

I/We authorize the physicians at the University of Arkansas for Medical Sciences, Little Rock, Arkansas, and/or their designees, to perform an autopsy on the remains of

____
(Name of deceased)

and I/we authorize the removal and retention or use for diagnostic, research, or educational purposes of such organs, tissues, and parts as the physicians at the University of Arkansas for Medical Sciences deem proper. This includes the placenta for fetal/neonatal loss. This authorization is subject to and expressly conditional upon the following restrictions **(please check one):**

[ ] No restrictions

[ ] Chest and abdomen only

[ ] Brain only

[ ] Other (please specify) ______________________

I/We wish the remains to be released to:

______________________________ ______________________ __________
(Name of Undertaking Establishment) (City) (State)

I/We are requesting an autopsy to answer the following question(s):

____

____

____

____

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

AUTOPSY STATUS

Consent for autopsy may be provided by whichever one of the following assumes custody of the body for final disposition:

1. Spouse
2. Adult child
3. Parent
4. Adult sibling, grandparent, or adult grandchildren
5. Guardian
6. Other adult next of kin (aunt, uncle, cousin, etc.)
7. In the absence of one of the above, an adult friend or person who has assumed custody of the body for final disposition.

I/We represent that I am/we are the ________________________ of the deceased and by law entitled to
(Relationship)
control disposition of the remains and assume custody of the body for final disposition.

Is there any person in a higher priority category to the person signing the consent?
[ ] Yes [ ] No

Do you have knowledge that any member of the authorizing category or higher priority category opposes the autopsy?
[ ] Yes [ ] No

______________________________ ____________ ____________
Signature (or write telephone consent) Date Time

______________________________ ______________________
Printed Name Contact Number

Signature of Physician obtaining consent:

______________________________ ____________ ____________
Signature of Physician obtaining consent Date Time

______________________________ ______________________
Printed Name Contact Number

Witnesses (two required):

______________________________ ____________ ____________
Signature (Witness 1) Date Time

______________________________ ____________ ____________
Signature (Witness 2) Date Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

PROBLEM ORIENTED AUTOPSY REQUEST SHEET

Remove this page prior to obtaining family signature and submit to the pathology department with the Autopsy Status form. **This form is not required for a fetal demise 12-19 weeks.**

Brief Clinical Summary:

____
____
____
____
____
____

Clinical Diagnosis

____
____

Specific questions that you would like answered (example: "The patient developed sudden shortness of breath. Is there a pulmonary embolus?")

____
____
____
____

Signature: ____ **Date:** ____________ **Time:** ____________

Contact number: ______________________

Note: An autopsy will NOT be performed without receipt of this page.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

FETAL DEMISE 12-19 WEEKS

If surgical pathology examination is **refused**, complete **FORM A** of this form. If surgical pathology examination permission is **granted**, complete **FORM B** of this form.

FORM A

Surgical pathology permission refused [ ]

Release the remains of

____
(Name of deceased)

to:

______________________ ______________ __________
(Name of Undertaking Establishment) (City) (State)

Do not write below this line – for Pathology use only

BODY RECEIPT

I certify that the remains of the above-named patient, after proper identification, were received by me for the purpose of burial.

____
Signature

____
(Name of Undertaking Establishment)

____

____
Address

__________ __________
Date Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

FETAL DEMISE 12-19 WEEKS

Form B

Telephone Consent: [ ] Yes [ ] No

(See Department of Pathology Procedures Manual located at all nursing stations for appropriate procedure for obtaining telephone consent)

This form does NOT authorize the use of organs, tissues, or parts for transplantation.

I/We authorize the physicians at the University of Arkansas for Medical Sciences, Little Rock, Arkansas, and/or their designees, to perform a surgical pathology examination on the remains of

____

(Name of deceased)

and I/we authorize the removal and retention or use for diagnostic, research, or educational purposes of such organs, tissues, and parts as the physicians at the University of Arkansas for Medical Sciences deem proper. **I authorize evaluation of the placenta (if available) for histologic examination.** This authorization is subject to and expressly conditional upon the following restrictions **(please check one):**

[ ] No restrictions

[ ] Gross examination only

[ ] Gross examination and cytogenetic analysis only

I/We wish the remains to be released to:

______________________________ ____________________ __________

(Name of Undertaking Establishment) (City) (State)

I/We are requesting a surgical pathology examination to answer the following question(s):

____

____

____

____

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

FETAL DEMISE 12-19 WEEKS

Consent for surgical pathology examination may be provided by whichever one of the following assumes custody of the body for final disposition:

1. Parent (mother preferred, but father may sign if listed on birth certificate)
2. Adult sibling, grandparent
3. Guardian
4. Other adult next of kin (aunt, uncle, cousin, etc.)
5. In the absence of one of the above, an adult friend or person who has assumed custody of the body for final disposition.

I/We represent that I am/we are the ______________________________ of the deceased and by law entitled to
(Relationship)
control disposition of the remains and assume custody of the body for final disposition.

Is there any person in a higher priority category to the person signing the consent?
[ ] Yes [ ] No

Do you have knowledge that any member of the authorizing category or higher priority category opposes the surgical pathology examination?
[ ] Yes [ ] No

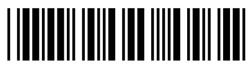
Signature (or write telephone consent)	Date	Time
Printed Name	Contact Number	

Signature of Physician obtaining consent:

Signature of Physician obtaining consent	Date	Time
Printed Name	Contact Number	

Witnesses (two required):

Signature (Witness 1)	Date	Time
Signature (Witness 2)	Date	Time



(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

Instructions for Obtaining Autopsy/Surgical Pathology Authorization

Note: This page is for informational purposes only and should be discarded prior to presenting the autopsy status to the family for signature.

Problem-Oriented Autopsy Sheet:

The Problem-Oriented Autopsy Report Sheet must be completed by the requesting physician and submitted to the Pathology Department along with the Autopsy Status Form.

Issues Related to Consent:

Consent for autopsy may be provided by the person who assumes custody of the body for final disposition. Refer to the list on Autopsy Status Form B.

1. In addition, autopsy consent will be accepted from a minor mother. If the parents are unmarried, autopsy consent may be accepted from the father – whether adult or minor - if he is listed as the father on the birth certificate. Consent from both parents is preferable, but not required.
2. A couple who is legally divorced has relinquished all rights of kinship to each other.
3. "Common law" marriages are not recognized in Arkansas.
4. If more than one person assumes custody of the body for final disposition, consent to autopsy from one of them is deemed sufficient.

Any questions about obtaining consent for autopsy may be referred to the Office of General Counsel at 501-686-7608.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

Love Lives Support

Love Lives is a UAMS bereavement support program committed to caring for you during this difficult time. One of the services we provide is photographs of your baby. Your nurse will speak with you about the process and what photos we may be able to provide to preserve these precious memories. If you like, we can give you a photo to take home with you, and we can also mail you a CD of all the photos of your baby to the address you provide. You and your family can view these pictures when you feel ready. There is no charge for this service. We are sorry for your loss and hope these photos help your family to heal. If you would like to have photographs taken, please complete the information below.

Photography Consent Form

I, ____ hereby consent to the taking of photographs of my baby, including myself and other family members. I understand that the photographs are not a part of my baby's medical record and are for personal use and will be provided to me by UAMS. These images are not for documentation or diagnostic purposes. The photographs may be used for UAMS health care operations such as performance improvement and educational purposes within UAMS. Other than for health care operations, photographs that identify me, my baby and other family members will be released outside UAMS only upon written authorization from me or my legal representative. The photographs will be digitally stored in a secure manner at UAMS and will only be retained for a limited period of time in case a replacement is needed.

☐ I desire to have **the photographs taken and receive the CD**. These will also be placed in the secure image repository with the ability to be obtained for up to 2 years.

☐ I desire to have the photographs taken and be placed in the secure image repository with the ability to obtain for up to 2 years. At this time, I **do NOT wish to receive the CD** with photographs.

☐ I **DECLINE** to have photographs taken. I do understand that when this option is selected then **NO** photographs will be taken or placed in the image repository.

Baby's Name: ____ Baby's Birth Date: ___________________________

Mother's Full Name: ______________________________________ Phone Number: _____________________________

Mailing Address: ____

Withdrawal of Consent – I understand that I am not required to sign this Consent. During the filming, I have the right to stop the filming at any time.

Release of Liability – I agree that UAMS, including its governing Board, physicians, agents and employees, are hereby released from legal responsibly or liability for the access and release of my photographs or other images to the extent indicated and authorized herein.

Signature of
Baby's Mother: ____ Date: ____________ Time: ____________

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

Photography Consent Form *(cont.)*

If mother is unable to sign, others who are authorized by law to sign on behalf of the baby, such as the baby's father, court appointed guardian of baby, or other legal representative.

Legal
Representative: ____ Date: ____________ Time: ____________

If Legal Representative, state relationship to Baby: ____

UAMS
For a Better State of Health

Options for families after a loss

Funeral Home:

Funeral homes can provide a funeral service and burial of your baby, or perform cremation. The funeral home may come to the hospital to pick up your baby, or you may choose to transport your baby to the funeral home yourself. *Not all funeral homes allow self-transport.* Our staff can give you a list of funeral homes in your area. Our staff will also help you complete all of the necessary paperwork. There is also additional information in the Love Lives *Guide to Grief and Healing* booklet on planning a service for your baby.

Options at UAMS:

You may also choose for UAMS to arrange cremation and final disposition, but if you select this option you will not be able to receive the cremains.