



EMR400420

**PathWest - Perinatal Pathology
CONSENT FOR CREMATION
AND MEMENTOS
MISCARRIED OR STILLBORN BABY
LESS THAN 28 WEEKS GESTATION**

Med Rec No: _____
Surname: _____
Given Name: _____
Gender: _____ D.O.B. : ____/____/____
Hospital: _____

After discussion of cremation options with Pastoral Care (and/or appropriate staff member),
I/we _____ hereby request PathWest Perinatal Pathology to cremate
my/our baby at King Edward Memorial Hospital.

Baby's First Name: _____ Surname: _____
Date of Delivery/Birth: ____/____/____ Gestation: ____/____/40
Father/Partner First Name: _____ Surname: _____

Preferred Contact Method : Phone or Email (please note if choosing Interment email is required)
Contact number: _____ Email: _____

I understand that I can only choose ONE option. Please tick only ONE of the following options either A or B:

A. Interment in the KEMH Memorial Garden
I/we wish for my/our baby's ashes to be interred communally in the
KEMH Memorial Garden at the monthly Interment of Ashes Service.

Date of Service: ____/____/____

I/we wish for my/our baby's name to be read aloud at the
Interment of Ashes Service: Yes No

Please Note: The service is held once a month on the last Thursday
of the month except for Public Holidays and December. All parents
external to KEMH will be sent/emailed a letter and brochure with the
date, time and location of the Service in which your baby's ashes will
be included.

I/we do not wish to be sent/emailed a letter and brochure with the
date, time and location of the Service.

B. Return of Separate Ashes
I/we wish to collect my/our baby's ashes from the following place:
 KEMH PathWest Perinatal Pathology (Ph: 6458 2730)
 Pastoral Care Services _____ (hospital)
 Hospital / GP / Health Centre (please state below):

Name & Address: _____

For multiple births: Combine ashes Individual ashes

Disclaimer: All ashes not collected within 12 months of signing this
form will be interred in the King Edward Memorial Garden.

Mementos – If at all possible, mementos of your baby will be created and are available upon request unless declined.

Disclaimer: All belongings will be cremated with your baby unless otherwise stated below. Perinatal Pathology cannot be responsible for
belongings not received. Please be aware that metals, hard plastics and large objects cannot be cremated.

Please select the mementos you would like to collect:

Photos Hand & Footprints
 Belongings to be returned

(please state which belongings you would like returned):

Please select your collection preference:

I will collect with Separate Ashes **or** at the Interment Service
 I will contact Perinatal pathology to collect
 Please Post to my home address

Decline of mementos: I understand that by declining the mementos below, they will not be taken and will not be available to me.

I do not give permission for **Photos** to be taken of my baby.
 I do not give permission for **Hand & Footprints** to be taken of my baby.

Any Special Instructions (e.g. hold cremation until after viewing etc.):

DISCLAIMER: Perinatal Pathology will NOT cremate your baby before three (3) calendar days of this Form being signed and dated.

Signature: _____ Relationship to Baby: _____

Witness Name: _____ Witness Signature: _____

Date: ____/____/____ Time: ____:____ AM/PM (Witness must be a staff member)

Verbal Consent: I, _____, hereby declare that the parents of baby: _____
have given their verbal consent for cremation as indicated above.

Signature: _____ Date: ____/____/____ Time: ____:____ AM/PM