PRINTING GUIDE
Stillbirths/Miscarriages: Pages 1, 2, 3, 6 & 7
Neonates: Pages 1, 2, 4, 6 & 7
Children: Pages 1, 2, 5, 6 & 7

CONSENT FOR POST MORTEM EXAMINATION (NON-CORONIAL)

PERINATAL & PAEDIATRIC EXAMINATION

AFFIX HOSPITAL LABEL

Hospital of Origin:
Med Rec. No: _____
Surname: _____
Given Name: _____
DOB: ___/___/_____

PART A: SENIOR AVAILABLE NEXT OF KIN CONSENT

- I have read/had explained and understood the Post Mortem Examination Information.
- I have had the opportunity to ask questions about the Post Mortem Examination process, this Consent Form and any other aspects of the post mortem examination.
- I have received sufficient information to enable me to reach an informed decision and have been given adequate time to make my decision.
- I confirm that my consent is free from coercion and freely given.
- I am not aware of any objection to the post mortem being performed.
- I understand that I can limit the extent of the examination and that the more complete the examination, the more information the final report will contain.
- I understand PathWest will share the report and photographs with my treating doctor/doctors, if requested.
- I understand that my baby/child will be received at an accredited PathWest facility (Perth Children's Hospital, King Edward Memorial Hospital or Fiona Stanley Hospital) where preparation and examination will be done. I understand that given the various technical components of a post mortem, my baby/child may need to be moved between accredited facilities, as determined by the conducting pathologist.
- I understand I will be provided with an opportunity to receive appropriate feedback on the findings of any pathology examination.

CONSENT TO POST MORTEM EXAMINATION (Senior Clinicians only to get consent - see pg.7 for details)

Consent for the following Post Mortem Examination has been given; (Please tick ONE box)

☐ **Full Examination** ☐ **External Examination** ☐ **Limited Examination**

I have chosen a **Limited Examination.** Please examine the following only;

☐ Head ☐ Chest ☐ Abdomen ☐ Other _____

CONSENT TO RETENTION, USE OF AND DISPOSAL OF ORGANS AND TISSUE

Yes / No I consent to tissue, apart from routine samples taken for histology, being retained following the post mortem.

Yes / No I consent to organ(s) being retained for a limited period following the post mortem.
Organ(s): _____ Duration: _____ (days)

Specify method of organ disposal for any retained organs once the examination is complete:

☐ I wish for the organs to be returned to the body prior to release/cremation.

☐ I request that PathWest cremate and dispose of the organs in a lawful and respectful way.

☐ I will arrange for the organs to be disposed of in a lawful manner by a funeral home.

SIGNATURE OF SENIOR AVAILABLE NEXT OF KIN

I (print name): _____ Relationship to deceased: _____

hereby give consent for a post mortem examination to be performed, subject to the conditions above, on

(print name): _____

Signed: _____ Date: _____ / _____ / _____

PRINTING GUIDE
Stillbirths/Miscarriages: Pages 1, 2, 3, 6 & 7
Neonates: Pages 1, 2, 4, 6 & 7
Children: Pages 1, 2, 5, 6 & 7

PART B: SENIOR CLINICIAN CERTIFYING CONSENT HAS BEEN OBTAINED AND ALL RELEVANT INFORMATION HAS BEEN PROVIDED

Senior Clinician Name & Title: _____

I hereby declare that the senior available next of kin has been provided with all the relevant information to make an informed decision. I have discussed all points raised on this form and the senior available next of kin has given informed consent for a post mortem examination to be performed and has indicated, where required, any conditions of their consent.

Senior Clinician Signature: _____ Date: ____/ ____/ _____

PART C: VERBAL CONSENT SENIOR AVAILABLE NEXT OF KIN

I hereby declare that (print name/s): _____

relationship to deceased: _____

has been provided with all the relevant information. I have indicated, where required, the conditions of consent. I have discussed all points raised on this form and have received informed verbal consent for a post mortem examination, subject to the conditions on page 1, to be performed on:

(print name) : _____

Senior Clinician Name & Title: _____

Senior Clinician Signature: _____ Date: ____/ _____/ _____

PART D: CONSULTANT SIGNATURE OR NAME

The Consent for Post Mortem Examination will not be accepted without the signature or name of a Consultant. This is to ensure that the results from the post mortem are forwarded appropriately. For the purposes of this form, a Consultant is defined as follows: A Consultant Obstetrician, a District Medical Officer, a Senior Medical Officer or a GP Obstetrician.

Name: _____ Signature: _____

Provider number: _____ Date: ____/ ____/ ____

If the Consultant is unavailable to sign this form, then their name must be provided below to ensure the post mortem result is sent to them.

Consultant name:_____

PRINTING GUIDE
Stillbirths/Miscarriages: Pages 1, 2, 3, 6 & 7
Neonates: Pages 1, 2, 4, 6 & 7
Children: Pages 1, 2, 5, 6 & 7

PART E: CLINICAL HISTORY (either part 1, 2 or 3 should be completed).
CLINICAL INFORMATION TO BE COMPLETED BY CLINICAL STAFF

(1) For MISCARRIAGES, FETAL DEATHS or STILLBIRTHS (REGARDLESS OF GESTATIONAL AGE):

Present Pregnancy: FDIU ☐ TOP ☐

Labour: Spontaneous ☐ Induced ☐

Estimated Gestation, by: LMP: _____ Dates: _____ U/S: _____

Gravida: _____ Parity: _____

Antenatal history (Including PROM, bleeding, hypertension, chorioamnionitis etc.):

Maternal Medical History:	**Known Fetal Abnormalities:**

Maternal Investigation Results (Including NIPT, diagnostic genomics, imaging etc.):
This should include information or copies of Radiology and Genetic reports where applicable.

Previous Obstetric History:

What specific questions would you, the requesting clinician, or next of kin like answered from this examination?

PRINTING GUIDE
Stillbirths/Miscarriages: Pages 1, 2, 3, 6 & 7
Neonates: Pages 1, 2, 4, 6 & 7
Children: Pages 1, 2, 5, 6 & 7

PART E: CLINICAL HISTORY (either part 1, 2 or 3 should be completed).
CLINICAL INFORMATION TO BE COMPLETED BY CLINICAL STAFF

(2) NEONATES (up to 28 days of life) *or* INFANTS (28 days to one year of life)

Baby Information

Presentation: ☐ Breech ☐ Cephalic Liquor _____

Onset: ☐ Spontaneous ☐ Induced

☐ Vaginal Birth ☐ Caesarean ☐ Assisted Birth (forceps or vacuum)

Date of Birth ____/____/_____ Time of Birth ____: ____ AM / PM

Date of Death ____/____/_____ Time of Death ___ : ____ AM / PM

Place of Birth (Hospital/Ward/other): _____

Sex: Male / Female Birth Weight: _____g Apgar Scores: _____

Resuscitation Attempts: YES / NO

Age; Years: _____ Months: _____ Days: _____ Hours: _____

CLINICAL HISTORY:
This should include information or copies of Radiology and Genetic reports where applicable and details of ventilator support and duration, intensive care and surgical interventions etc.

Previous History and other relevant medical details including infectious disease risks:

Maternal History:

What specific questions would you, the requesting clinician, or next of kin like answered from this post mortem examination?

PART E: CLINICAL HISTORY (either part 1, 2 or 3 should be completed).
CLINICAL INFORMATION TO BE COMPLETED BY CLINICAL STAFF

(3) For CHILDREN (1 year to 18 years of life)

CLINICAL HISTORY:
This should include information or copies of Radiology and Genetic reports where applicable and details of ventilator support and duration, intensive care and surgical interventions etc.

Previous History and other relevant medical details including infectious disease risks:

What specific questions would you, the requesting clinician, or next of kin like answered from this post mortem examination?

PART F: CLINICIAN ATTENDANCE

The following Clinicians wish to attend the Post Mortem Examination;
(PLEASE PRINT and provide a contact number)

Dr: _____ Contact Number: _____

Dr: _____ Contact Number: _____

PART G: POST MORTEM RESULTS

The results of the post mortem are automatically sent to the Consultant listed at Part D, page 2. Further copies can be provided to medical staff only. Please provide details for additional copies:

Dr & Address: _____

Dr & Address: _____

A plain language report may be provided to the health care professional for the benefit of the Senior Available Next of Kin:

Dr & Address: _____

NOTE: Technical and plain language reports cannot be sent directly to the Parent/Senior Available Next of Kin. The name of a GP or other Doctor must be provided.

PART H: PAPERWORK REQUIREMENTS

PAPERWORK TO BE COMPLETED BY CLINICAL STAFF:

When sending a baby for examination, please send the completed forms mentioned below with the unfixed placenta (if available) and a note of any available details of funeral arrangements.

Miscarriages or Fetal Deaths (Less than 20 weeks) (Cremated at KEMH):

1. NCC Form 3 – PathWest Consent for Cremation & Mementos (Stillbirths less than 28 weeks gestation)

Miscarriages or Fetal Deaths (Less than 20 weeks) (Private Burial or Private Cremation):

1. NCC Form 4 – PathWest Consent for Mementos (Babies for Private Burial / Private Cremation)

Stillbirths (Cremated at KEMH):

1. Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201)
2. NCC Form 3 – PathWest Consent for Cremation & Mementos (Stillbirths less than 28 weeks gestation)

Stillbirths & Neonates (Private Burial or Private Cremation):

1. Medical Certificate of Cause of Stillbirth or Neonatal Death (BDM 201)
2. Certificate of Medical Attendant (Form 7)
3. NCC Form 4 – PathWest Consent for Mementos (Babies for Private Burial / Private Cremation)

Infant & Child Deaths:

1. Medical Certificate Cause of Death (BDM202)
2. Certificate of Medical Attendant (Form 7)

If you have any queries regarding any aspects of the post mortem arrangements, please contact the Post Mortem Coordinator for PathWest Perinatal Pathology and Paediatric Anatomical Pathology on (08) 6458 2730.

Diagnostic Genomics testing requires completion of a specific PathWest consent form and is not included in the Post Mortem consent. Please fill in a separate form if Diagnostic Testing is required.

This section to be completed by the PathWest Post Mortem Coordinator and Designated Officer of the Hospital for the purpose of the Human Tissue and Transplant Act 1982 only.

PART I: To be completed by the POST MORTEM COORDINATOR

I certify that part "B" or part "C" has been completed as per the *Non-Coronial Post-Mortem Examinations Code of Practice 2021.*

Print Name: _____

Signed: _____ Date: _____ / _____ / _____

PART J: To be completed by the DESIGNATED OFFICER OF THE HOSPITAL for the purposes of the *Human Tissue and Transplant Act 1982* giving authority to perform a post mortem examination (Not to be signed by requesting Doctor).

I (print name): _____

Being a designated officer under the *Human Tissue and Transplant Act 1982,* authorise a post mortem examination to be performed on the above name deceased.

Signature: _____ Date: _____ / _____ /_____

PART K: PATHOLOGIST performing the post mortem:

Dr: _____

PART L: GUIDELINE FOR OBTAINING CONSENT

The approach to the family regarding post mortem is most appropriately made by the Senior Clinician treating the patient. This is not a duty to be delegated to a junior medical officer or untrained
interviewing officer. Requesting a post mortem and discussing organ retention and other sensitive information should be conducted face to face wherever possible.

A Senior Clinician is defined as follows:

- A Consultant
- District medical officer (DMO)
- Senior medical officer (SMO)
- GP obstetrician
- A fellow in obstetrics and gynaecology
- A clinical midwife who is a subspecialist in the perinatal loss service
- A senior registrar who is specialising in obstetrics and gynaecology

All the above may seek consent to undertake a post mortem. The Senior Clinician's signature must be provided and their name clearly legible. Where a clinical midwife or a registrar obtains informed consent, they must not only sign the consent form, but also provide the name of the Consultant, DMO, SMO or GP obstetrician (who should be aware that the post mortem is taking place) to ensure the post mortem report is sent to them.