To: Funeral Director ______________________________
☐ Pending

Name of patient ______________________________

Medical record number ______________________________

______________	______________	______________
Next of kin	Relationship	Phone number
		______________
		Alternate phone number

Date of death ______________ Time of death: ______________

Attending physician and/or physician declaring death ______________

____

____

For clarification of time of death or attending physicians, call Medical Records.
☐ University Tower 559-4024 ☐ Clarkson Tower 552-2121

Completed by ______________________________

Personal belongings accompanying body ______________________________

____

____

____

Accepted by ______________________________ Witness ______________
(Funeral Home Representative)

FUNERAL HOME INFORMATION FORM

Original: Pathology Copy: Funeral Home

CLR-0012 (Rev. 6/06)

PT NAME

MR #

LEGAL NEXT OF KIN WORKSHEET
(FOR AUTHORIZATION FOR AUTOPSY)

Legal next of kin information obtained from: ____________________

Relationship to deceased: ____________________

Identification of legal next of kin – priority ranked:

1. **Is (or was) there a spouse?** ☐ No ☐ Yes
   - ☐ Living
   - ☐ Deceased
   - ☐ Legally Divorced

   Comments: ____________________

   If **Yes** and **living** are selected above the legal next of kin has been identified. Only in extenuating circumstances would any other relative be permitted to authorize an autopsy. See note below on POA.

   If there is a spouse but the location of this person is unknown, attempts must be made to locate this person. We cannot accept the adult child's authorization. For any question related to who may authorize an autopsy when there is the ***possibility*** of a living spouse please contact the staff chaplain on-call.

2. **Is there an adult child (19 years or older)?** ☐ No ☐ Yes
   - ☐ Living
   - ☐ Deceased

   Comments: ____________________

3. **Parents?**

   ☐ Father ☐ Deceased
   ☐ Mother ☐ Deceased

   Comments: ____________________

4. **Siblings?**

   ☐ No ☐ Yes

   Comments: ____________________

NOTE:
The Power of Attorney ceases when the patient dies.
If someone states they have POA for a living, "legal next of kin" who is unable to make decisions for him/herself or has been declared incompetent, you must obtain written documentation of this fact for the medical record. A copy must also be attached to the authorization for autopsy form.

Please look through the medical record to verify that there is no conflicting information related to legal next of kin. If there is, please follow up with the family and document your findings.

Information obtained by: ____________________ Date: ____________________

CONSNT

PT NAME

MR #

A. Coroner's Notification And Release

Coroner's Case: ☐ Yes ☐ No

Coroner Notified: ☐ Yes ☐ No

Name of Coroner: ____________________

Released by Coroner: ☐ Yes ☐ No

Date/Time Released: ____________________

Employee Interviewed by Coroner: ____________________

B. Authorization For Autopsy

Date: ____________________ Time: ______________

I (We) do request and authorize the physicians in attendance at The Nebraska Medical Center to perform an autopsy on the body of ____, and I (we) authorize the removal and retention or use for diagnostic, educational, or scientific purposes of such organs, tissues, and parts as such physicians and surgeons deem proper. When a complete autopsy is performed, all major internal organs are retained in whole or in part for purposes of diagnosis, education, and investigation of disease processes.

This authority is granted for:

Complete Autopsy_____ Trunk Only_____ Other (specify) ____________________

I (We) affirm that I am (we are) the ______________________________ (relationship) of the deceased.

Signature of the next-of-kin/relationship: ____

C. Decline Of Autopsy

Date: ______________ Time: ____________

Autopsy offered by____________________ Family member declining autopsy: ____________________

D. Release To The Funeral Home

Date__________ Time__________

I (We) authorize the body of ____ to be released to

____

(Funeral Home) (City) (State) (Phone #)

____

Signature of Family Representative (Next-of-Kin Preferred) / Relationship

E. Receipt By Funeral Home

Date__________ Time__________

I hereby acknowledge receipt of the body of ____

____________________ ____________________

Signature of Funeral Home Representative Signature of Security/Witness

F.

EYE Donation Pending ☐ EYE Donation Completed/Declined ☐ _______ (Initials)

TISSUE Donation Pending ☐ TISSUE Donation Completed/Declined ☐ _______ (Initials)

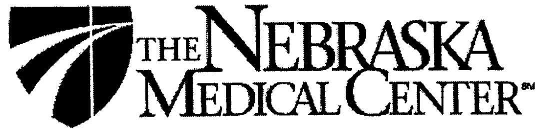
AUTHORIZATION FOR AUTOPSY AND FINAL DISPOSITION OF DECEASED PATIENTS

MIS-0139 (Rev. 7/09)

MISCELLANEOUS

White Copy - Medical Record *Yellow Copy - Pathology* *Pink Copy - Pastoral Care*

[Patient Label]



CLINICAL INFORMATION FOR AUTOPSY

This form is to be completed by the clinical staff responsible for signing out the patient. This form is to accompany the Authorization for Autopsy form along with the clinical record to the Department of Pathology and Microbiology.

Attending Service: ________________________________

Admission Date: ________________________________

Patient has/may have: HIV__________ AICD Device__________

TB__________ Other__________

Hepatitis A/B/C__________

Radioactive Agents Administered: Y / N

Key clinical issues/questions to be addressed at autopsy:

1) ____

2) ____

3) ____

________________________________ M.D. ( ) __________
Attending physician to be contacted before and after autopsy – Please Print Telephone or pager #

________________________________ M.D. ( ) __________
Fellow physician to be contacted before and after autopsy – Please Print Telephone or pager #

________________________________ M.D. ( ) __________
Resident physician to be contacted before and after autopsy – Please Print Telephone or pager #