VPAS

UR number
Surname
Given name/s
Date of birth Gender
(Affix baby's label)

Baby's label

UR number
Surname
Given name/s
Date of birth Gender
(Affix mother's label)

Mother's label

VPAS Victorian Perinatal Autopsy Service

Consent for perinatal post-mortem examination

SECTION 1

Interpreter required: ☐ Yes ☐ No

If Yes, requested language:

Interpreter's name (print)/ID reference :

Interpreter's translation provided: ☐ Phone ☐ In person

Date: / /

SECTION 2

The following checklist is provided to ensure that you (parent/legal guardian/s) have received adequate information.

The post-mortem will only proceed if YES has been answered to all questions

- I have received and/or read the *VPAS Deciding if your baby should have a post-mortem examination* information sheet ☐ Yes ☐ No
- I understand the options and reasons for performing the post-mortem. ☐ Yes ☐ No
- I have received satisfactory answers to my questions. ☐ Yes ☐ No
- I understand that as part of a thorough post-mortem examination, sometimes specific organs may need to be temporarily kept for further testing which may delay the burial or cremation. ☐ Yes ☐ No
- I understand that full and limited post-mortem examinations involve taking and keeping small tissue samples and bodily fluids for diagnostic testing. These tissue samples may be requested for research; however tissue samples cannot be used without approval by the hospital's Ethics Committee. ☐ Yes ☐ No
- In accordance with the law, tissue taken for diagnostic testing must be kept by the hospital for at least 25 years. ☐ Yes ☐ No

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Baby's label

UR number
Surname
Given name/s
Date of birth Gender
(Affix mother's label)

Mother's label

SECTION 3

Decision regarding post-mortem examination (please tick only one box)

☐ I consent to a full post-mortem examination (go to section 4), or

☐ I consent to a limited post-mortem examination. Specify what limitations you would like to set. For example:

- Is the examination limited to a particular organ system or part of the body.
- Are there specific limitations eg. no brain examination.
- If only specific tissue removal is allowed eg. a skin sample for genetic testing,

Full, limited and external examinations may include imaging and clinical photography that assist in assessment of physical abnormalities.

(go to section 4), or

☐ I consent to an External Post-mortem examination (go to section 5), or

☐ I do not consent to any type of Post-mortem examination (go to section 5)

SECTION 4

Decision following the examination of organs (only full or limited post-mortem)

Do you require all remaining tissue/organs to be returned to the body prior to release for burial or cremation?

☐ **Yes** ☐ **No** ☐ **N/A**

If you answered **No**, please indicate what you would like the hospital to do when the examination is completed (please tick only one box). This hospital:

☐ is to make arrangements for the lawful cremation or disposal of the remaining tissue/organs

☐ may retain the remaining tissue/organs for teaching and research approved by the hospitals ethics committee

SECTION 5

Parent/legal guardian signature/s

I/we have been given adequate time/sufficient information to make an informed decision (only one signature required).

Parent/legal guardian name:
Relationship to baby:
Signature:
Date: / /

Parent/legal guardian name:
Relationship to baby:
Signature:
Date: / /

SECTION 6

Witness statement

I have explained the nature and extent of the post-mortem examination and believe that the parent/legal guardian making the decision has understood the explanation. I have provided a copy of this form to the parent/legal guardian

Doctor's name (print): Doctor's provider number:

Doctor's signature: Date: / /