VPAS

Victorian Perinatal Autopsy Service

UR number

Surname

Given name/s

Date of birth Gender

(Affix baby's label)

Checklist for arranging a Perinatal Autopsy

Task	Initial when complete	Fax/email to lab and send with Baby ✔
Activate your hospital Bereavement Procedure.		N/A
Discuss perinatal autopsy with the family.		N/A
Provide family with written information about autopsy (information available at thewomens.org.au/reproductiveloss).		N/A
Download the forms from this link thewomens.org.au/VPASforms or obtain them through your local procedure.		N/A
Complete the **VPAS Consent for Perinatal Post Mortem Examination** form with the parents.		✔
Complete **VPAS Transport Authorisation Form** (authorisation for returning baby after PM to the family).		✔
Complete the death certificate (Medical Certificate of Cause of Perinatal Death – send a legible copy if using a pre-printed form or a copy of the certificate after completing the form via the Births Deaths and Marriages online portal). **PLEASE ensure a cause of death is documented eg FDIU, extreme prematurity etc.**		✔
Complete **VPAS Clinical Information Form: Before Commencement of Post Mortem.**		✔
Collate all relevant antenatal perinatal and postnatal clinical information to send with forms: • A copy of the mother's Victorian Maternity Record or equivalent • Birth summary • Discharge summary (if available) • Relevant medical and midwifery/nursing notes • All pathology tests for mother and baby • All imaging results or location/contact of where imaging performed		✔
Complete **VPAS Clinical Information Form: Before Commencement of Placental Pathology.**		✔
Complete a pathology request form and send the **fresh** Placenta (**no formalin**) requesting placental histopathology, placental swabs and molecular karyotype/microarray. **The placenta is a maternal specimen it must be labelled with maternal identifiers.**		✔

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(Affix baby's label)

Task	Initial when complete	Fax/email to lab and send with Baby ✔
When arranging the transportation to VPAS, ensure the VPAS Laboratory have confirmed they are able to receive the baby before departure to negotiate an acceptable arrival time. • Monash: mortuary@monashhealth.org • RCH: 03 8345 2562 • Austin: 03 9496 5285		N/A
Create three copies of all VPAS forms and other reports: • one hard copy to stay with the baby • one copy to medical records at your institution, and • one copy via fax or email to the VPAS Laboratory Contact methods for sending through referral documents to VPAS Laboratory: • Monash: mortuary@monashhealth.org • RCH: 03 8345 2562 • Austin: 03 9496 5285		✔
Before sending the baby, check the baby is wearing two correct and clear patient identification labels and that the documents are correctly labelled.		✔

CLINICAL TEAM CONTACT DETAILS

Please ensure each of the following are completed

Contact details of clinical staff member sending baby (RN/RM/other who has prepared baby/forms and checked ID)

Name:	Designation:
Email address:	Contact no:

Contact details of Doctor who has completed informed consent with family

Name:	Designation:
Email address:	Contact no:

Contact details of Nurse/Midwife Unit Manager (or clinical staff member during business hours with queries)

Name:	Mobile number:
Email address:	Phone and pager number:

Send all of the above including this checklist to the VPAS hub

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

Registered birth

(Baby shows signs of life at birth, regardless of gestation or does not show signs of life at birth and is at least 20 weeks gestation or weighs at least 400g at birth)

Interpreter required: ☐ Yes ☐ No

If Yes, Language: ______

Interpreter's name (print): ______

Date: / / ______

Interpreter's translation provided via phone or in person: ______

______

The following checklist is provided to ensure that you have received adequate information.

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

- I understand the options and reasons for performing the post mortem ☐ Yes ☐ No
- I have received and/or read information about the options of 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-mortems involve taking and keeping small tissue samples and bodily fluids for testing and by law must be kept for at least 25 years ☐ Yes ☐ No
- I understand that the tissue samples taken may be used by researchers; however tissue samples cannot be used without approval by the hospital's Ethics Committee ☐ Yes ☐ No
- I understand that no whole organs will be kept by the hospital without my consent ☐ Yes ☐ No

VPAS

UR number

Surname

Given name/s

Date of birth Gender

(Affix baby's label)

UR number

Surname

Given name/s

Date of birth Gender

(Affix mother's label)

Baby's label

Mother's label

Decision regarding post mortem examination (please tick one box)

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

☐ I consent to a Full Post Mortem examination

☐ I consent to a Limited Post Mortem examination

Limited to examining (please specify organs/tissues/genetic testing/cell culture)

☐ I consent to an External Post Mortem examination (this may include imaging and clinical photography that may assist in assessment of physical abnormalities)

☐ I do not consent to any type of Post Mortem examination

Decision regarding retained tissue/organs during a post mortem examination

Occasionally, specific organs may need to be temporarily kept for further testing and are unable to be returned prior to release for burial or cremation. Do you require all organs to be restored to the body prior to release? Yes ☐ No ☐

If you answered NO, please indicate what you would like the hospital to do when the examination is completed (please tick one box)

☐ The hospital is to make arrangements for the lawful cremation or disposal of the organs

☐ The hospital may retain the organs for teaching and ethically approved research purposes

Identification of parent/legal guardian being requested to make a decision regarding post mortem examination (only one signature is required)

I have received sufficient information to give informed consent and have been given adequate time to make the decision

Parent/legal guardian name granting consent:

Relationship to baby:

Signature:

Date:

I have received sufficient information to give informed consent and have been given adequate time to make the decision

Parent/legal guardian name granting consent:

Relationship to baby:

Signature:

Date:

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 Signature: Date: / /

I request that a copy of the post-mortem report be provided to

Doctor:

Address:

VPAS

Victorian Perinatal Autopsy Service

UR number	
Surname	
Given name/s	
Date of birth	Gender

(Affix patient label)

Clinical Information Form:
Before Commencement of Post Mortem Examination

Please clarify what clinical questions need to be answered by the post mortem examination:

Ancillary investigations require a separate request slip.

Copy for report to Unit/Doctor

Name:	Time and date of delivery:
Duration of pregnancy at delivery:	Stillborn estimated time from death to delivery: or Liveborn: post natal survival (m/h/d):
Time and date of death: ____:-____ (24 hour clock) ____/____/____ (dd/mm/yy)	Birth weight (recorded on death certificate):
Place of delivery/death (Hospital/Ward/Unit/Location):	

Maternal history

Maternal medical history (including diabetes mellitus, hypertension, medications, etc)	
Maternal past obstetric history (including brief summary of course and outcome of previous pregnancies); parity (gravid, para)	
Present pregnancy: LNMP EDD (Dates) EDD (Ultrasound – if different)	Multiple pregnancy Chorionicity (if known): Complications:
Antenatal screen: Blood group & Rh Maternal serum screen TORCH screen Hepatitis B&C Syphilis HIV	Other maternal investigations: Kleihauer test Auto antibodies Coagulation profile Group B Strep. Parvovirus

Maternal history (continued)

Other antenatal investigations/procedures:
Ultrasound(s) findings (including abnormal/normal anatomy, placenta);
Amniocentesis/chorionic villus sampling (FISH/Karyotyping); Fetal surgery

Please include copies of reports

Antenatal course (including premature rupture of membranes, bleeding, fever, hypertension, etc)

Labour:
Spontaneous/induced
Duration
Complications

Delivery:
Mode (vaginal, emergency/elective caesarean section – indication)
Presentation
Rupture of membranes
Liquor (including meconium)

Baby:
Liveborn/stillborn
APGARS

Neonatal course (if liveborn):
Resuscitation
Neonatal problems
Investigative and therapeutic procedures

Please continue writing if necessary:

Signature: **Print name:**
Designation:
Date: / /

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UR number	
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Given name/s	
Date of birth	Gender

(Affix maternal label)

Clinical Information Form:
Before commencement of Placental pathology

Please fill this form and include a signed placenta pathology request form:

Consultant/Team:
Indication for request:
Gestation:

Relevant clinical history

	Please State Yes (Y) or No (N)
Perinatal death	
Post-mortem	
Surface/subchorionic swabs taken for cultures	
Karyotype performed	
Preterm infant (<34/40 weeks)	
Prolonged rupture of membranes (>24hrs)	
Suspected maternal/fetal bacterial or viral infection	
Fetal growth restriction (FGR) or SGA	
Pre-eclampsia	
Essential hypertension	
Diabetes	
Placenta praevia	
Multiple pregnancy	
Type of multiple pregnancy	
Unexplained bleeding/clinical abruption	
Fetal anomaly	
Other relevant clinical history	
Relevant factors at time of labour/birth	

Signature:	**Print name:**
Designation:	
Date: / /	

VPAS_Form_4 Version 1, authorised 20/09/2021

VICTORIAN PERINATAL AUTOPSY SERVICE (VPAS)

Transport authorisation form

To:

Fax No:

From:

Contact No:

CC:

Date:

Number of pages including cover page:

Re: TRANSPORT AUTHORISATION FROM ANATOMICAL PATHOLOGY

The following information is intended for the addressee only and is CONFIDENTIAL.

The parents authorise baby ____
can be released into the care of Funeral Providers ____________________________________,
for the purposes of transportation

SIGNED BY PARENT/LEGAL GUARDIAN: ____

Name of Parent/Legal Guardian: ____

Date: ______/______/______

FUNERAL DIRECTORS: ____

Address: ____

Contact Details: Phone: ____________________________ Fax: ____________________________

GARMENTS AND MEMENTOES

I/we have provided garments and mementoes: ☐ No ☐ Yes

List items ____

____

____