The Mount Sinai Medical Center
One Gustave L. Levy Place
New York, NY 10029

MRN -
V -

REQUEST FOR POST-MORTEM EXAMINATION

Patient Care Unit: _____ **Date:** _____

Primary Attending: _____

NOTE: THIS DOCUMENT MUST BE COMPLETED FOR **ALL DECEASED PATIENTS** AND MUST BE MADE PART OF THE PATIENT'S RECORD.

PART I. PERMISSION

1. I hereby authorize a member of the medical staff of the Mount Sinai Hospital to perform a post mortem examination on the body of _____ for the purposes of (1) ascertaining the cause of death and (2) furthering medical knowledge. I further authorize the examination and retention and disposal of organs and/or tissues as the Mount Sinai Hospital may consider necessary or appropriate for such purposes. This authority is granted subject to the following restrictions and special instructions.

☐ No restrictions

☐ Restriction(s) as follows _____ time limit _____

2. I have been given the opportunity to ask any questions about the post mortem examination. All my questions have been answered fully and satisfactorily. I acknowledge that I have read this document in its entirety and all blank spaces in this part have been completed prior to my signing.

_____ MD
(SIGNATURE OF WITNESS)

_____
(SIGNATURE OF AUTHORIZING PERSON)

_____ MD
(PRINT NAME OF WITNESS)

_____
(PRINT NAME OF AUTHORIZING PERSON)

_____
(SIGNATURE OF AUTHORIZED ADMINISTRATIVE HOSPITAL OFFICIAL)

_____
(RELATIONSHIP TO DECEASED)

Name of Physician(s) to whom report should be sent: ☐ Attending Physician ☐ Others _____

_____

SPECIAL PRECAUTIONS FOR PROSECTOR:

PART II. IF PERMISSION FOR POST MORTEM EXAMINATION NOT GRANTED, COMPLETE THIS PART.

Reason was ☐ Religious ☐ Other (Specify) _____

If Religious objections were raised, was Clergy consulted? ☐ Yes ☐ No

Did a Housestaff Physician speak to the family: ☐ Yes ☐ No _____
(NAME OF HOUSESTAFF PHYSICIAN)

Did the Attending speak to the family? ☐ Yes ☐ No _____
(NAME OF ATTENDING PHYSICIAN)