

FLETCHER ALLEN HEALTH CARE

PERMISSION FOR AUTOPSY

Date \_\_\_\_\_ Time \_\_\_\_\_

I (we) hereby grant permission for a complete postmortem examination, including the removal and retention or use for diagnostic, scientific, educational, or therapeutic purposes of such organs, tissues and parts at the physicians in attendance at Fletcher Allen Health Care may deem desirable, on the remains of

(Print Name of Deceased) \_\_\_\_\_

This authority is granted subject to the following restrictions (if none, write "none"):

\_\_\_\_\_  
\_\_\_\_\_

The following special examinations are requested: \_\_\_\_\_

\_\_\_\_\_

I (we) represent that I am (we are) the nearest next-of-kin of the deceased and entitled by law to control the disposition of the remains.

Print Name(s): \_\_\_\_\_ Relationship(s): \_\_\_\_\_

Signature: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_

Permission obtained by: Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

\_\_\_\_\_  
Telephone or pager number

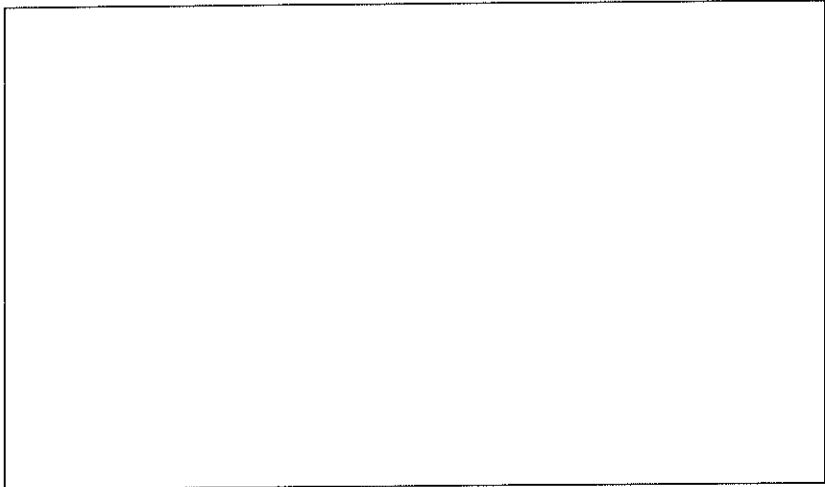
Other witness (required if telephone permission):

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

(PLEASE COMPLETE OTHER SIDE)

**FLETCHER ALLEN HEALTH CARE**



Addressograph identification

**REPORT OF DEATH**

Patient's Name: \_\_\_\_\_

Last Name

First Name

Middle Initial

Service: \_\_\_\_\_ Hospital No.: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date and Time of Death: \_\_\_\_\_

Campus: \_\_\_\_\_ MCHV \_\_\_\_\_ FAH \_\_\_\_\_ OUTPATIENT

Autopsy Permission Obtained by: \_\_\_\_\_

Pager or Office Telephone No: \_\_\_\_\_

Chief Clinical Diagnoses:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**(See Other Side)**