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

Baby's label	Mother's label
UR number	UR number
Surname	Surname
Given name/s	Given name/s
Date of birth Gender	Date of birth Gender
(Affix baby's label)	(Affix 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	**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:	Parent/legal guardian name granting consent:
Relationship to baby:	Relationship to baby:
Signature:	Signature:
Date:	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: