



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.

(SIGNATURE OF WITNESS) MD

(SIGNATURE OF AUTHORIZING PERSON)

(PRINT NAME OF WITNESS) MD

(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)