BSVHS-015

Bon Secours

Place patient label inside box (if no patient label, complete below)
Mother's Label

Name: _____

DOB: _____

MR #: _____

Facility / Office Name: _____

Informed Consent and Authorization

Perinatal Loss and Products of Conception

The product of conception less than 20 weeks gestation will go to Anatomical Pathology for examination

Informed Consent for Genetic Testing ☐ SEE REQUEST BELOW ☐ NO REQUEST

I/we, _____, hereby give my consent to have Genetic Testing
Parent(s) / Legal Guardian(s)

performed on the remains of my fetus/infant, as requested by my provider.

It has been explained to me by a provider and I understand that the results of the testing will be provided to me by a provider after my discharge.

_____	_____	_____	_____ ☐AM ☐PM
Parent / Legal Guardian Signature	Printed Name	Date	Time
_____	_____	_____	_____ ☐AM ☐PM
Witness Signature	Printed Name	Date	Time
_____	_____	_____	_____ ☐AM ☐PM
Provider Signature	Printed Name	Date	Time

Authorization for Release of Remains

Please check one option

☐ I authorize the hospital to release the remains to the hospital designated funeral home for burial. Burial is available for any remains and for any neonate.

- ☐ Please have the funeral home contact me about remembrance services, contact # _____
- ☐ Please DO NOT have the funeral home contact me about remembrance services.

☐ I authorize the hospital to release the remains for private burial by: _____
(Funeral Home Name/Other)

Released to: _____ Date: _____ Time: _____ ☐AM ☐PM Signature: _____

☐ I am currently undecided about disposition.

A Nursing Supervisor will contact you within 1 week for a decision at the following # _____

If no decision is made, the hospital will release the remains to the hospital designated funeral home.

The above options were explained to me and I request the disposition indicated above.

_____	_____	_____	_____ ☐AM ☐PM
Parent / Legal Guardian Signature	Printed Name	Date	Time
_____	_____	_____	_____ ☐AM ☐PM
Witness Signature	Printed Name	Date	Time