

Autopsy Request Checklist

The following checklist must be completed in its entirety prior to sending the decedent for autopsy.

Demographic Information:

Decedent's Name: _____

Please fill out one of the two sections below based on the provided underlined definitions:

Stillborn perinatal autopsy: fetal or peripartum/intrapartum demise with no signs of life at time of delivery

- Mother's Name: _____
- Mother's Date of Birth: ____/____/____
- Decedent's Date and Time of Birth/Delivery: ____/____/____ at ____:____ AM / PM
- Decedent's Gestational Age at Time of Delivery: _____ weeks

Liveborn perinatal/pediatric autopsy: all other cases with documented signs of life at time of delivery

- Decedent's Date of Birth: ____/____/____
- Decedent's Date and Time of Death: ____/____/____ at ____:____ AM / PM
- Age at Time of Death: _____ days / weeks / months / years

Brief clinical summary: _____

Reason for autopsy: _____

Requesting Clinician Contact Information:

Full Name: _____

Phone Number: _____

By using and sending this Requisition Form to CHOP Outreach Lab for laboratory testing, you, the sender, acknowledges and agree that you have read and agree to the CHOP Terms and Conditions posted at www.chop.edu/labs and agree to pay CHOP the rates in CHOP's fee schedule in effect on the date the specimen is received.

Client or Referring Address (send results to):	Billing Address (if different from client):
Name:	Name:
Address:	Address:
City:	City:
State/Zip:	State/Zip:
Phone:	Phone:
Fax:	Fax:

- Call CHOP Pathology at 215-590-1728 to provide Decedent's name and estimated time of body arrival.
- Complete **Children's Hospital of Philadelphia Authorization for Autopsy** (page 4)
 - Any restrictions must be clearly specified.
 - Signature by one parent is acceptable if there is only one legal parent or both parents agree but one is unable to sign.
 - Permission by telephone is acceptable only if witnessed by consenting provider (MD, DO, or APP) and one other person.
 - Form must be entirely completed to be rendered valid.
- Complete **Authorization for the Release of Remains** (page 5)
- Medical Records: Collect all relevant medical records from the referring physician/institution.
 - For stillborn/fetal demise cases:
 - Maternal history and physical
 - Maternal delivery note
 - Any available prenatal records
 - Prenatal genetic testing results, if performed
 - For liveborn/infant cases:
 - Infant deceased discharge note
 - Infant admission/history and physical note
 - Maternal delivery note, admission, prenatal records
 - Genetic testing results, if performed
 - Medical records must be transmitted to CHOP as follows:
 - Transmit electronic copies of records either by fax to 215-590-1736 or by secure email to chopapconsult@chop.edu.
 - Send paper records with the decedent to CHOP.
 - Release Epic EHR records to CHOP via Care Everywhere by including a Demographic sheet and either the decedent's or if stillborn mother's Epic Care Everywhere ID Number, which can be found in the patient's chart under the SnapShot tab: _____

**Department of Pathology and Laboratory Medicine
Division of Anatomic Pathology**

3401 Civic Center Blvd, Room 5NW27, Philadelphia, PA 19104
Phone: 215-590-1728 | Fax: 215-590-1736



Initiate transportation of body to The Children's Hospital of Philadelphia via funeral home or courier service. The referring institution is responsible for arranging transport and all fees associated with the transportation of the body.

- Body must be kept fresh and refrigerated (not frozen or in fixative) at all times.
- Ensure that the body is properly identified (wristband or toe tag must be attached to the body and include two identifiers, such as name, date of birth, MRN).
- Address: The Children's Hospital of Philadelphia
Department of Pathology, 5th Floor Main
Philadelphia, PA 19104

For fetal or perinatal autopsy:

- The placenta should accompany the body for CHOP pathologist examination.
- The placenta should be labeled with the mother's information (name and maternal date of birth, at minimum).
- Preferably, the placenta should be kept fresh and refrigerated prior to transport; however, if it has already been processed by the referring institution, please send report, slides, and/or blocks, and fixed specimen, if available.

Please indicate what is being sent from the placenta below (check all that apply):

- Fresh placenta intact
- Formalin-fixed placenta intact
- Formalin-fixed placenta, previously sectioned
- Placenta Blocks
- Placenta Slides
- Placenta Report

- If delivery took place at a different institution, please complete the Children's Hospital of Philadelphia **Authorization to Release/Obtain Patient Information** form with appropriate signature (page 6).

Karyotyping or other genetic testing: It is best that appropriate samples (amniocentesis, skin and/or placental tissue) be obtained at the referring institution and sent directly for analysis.

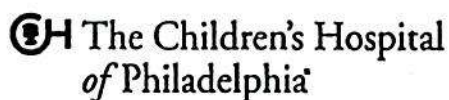
- Material already sent by the requesting physician
- Material not sent by the requesting physician and to be sent to CHOP
- Karyotyping/genetic testing not required

Additional Notes:

- Any karyotyping or genetic testing requested for a send-out by CHOP pathologist will incur additional cost.
- The placenta will be treated as a surgical specimen and billed accordingly.
- Preliminary autopsy report will be provided within 4 working days of the autopsy.
- Final autopsy report will be provided within 60 working days of the autopsy.
- If organs are to be returned to body, neuropathologic examination (brain and/or spinal cord) will not be performed.

Please return this checklist and all required documents as previously described via fax (215-590-1736) or email to chopapconsult@chop.edu and send paper records with the decedent to CHOP.

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AUTHORIZATION FOR AUTOPSY

Place patient label or complete blanks below:

NAME SEX M F

Age/Date of Birth

Name of Deceased

I (next of kin): _____, do hereby grant to the authorities of the Children's Hospital of Philadelphia, permission to perform a complete autopsy upon the body of

Deceased: _____, including removal, retention, study and photography of such organs, parts of organs, or tissues as are deemed necessary or desirable by the proper examining physician in order to determine the cause of death or for use in the medical research and teaching. I understand that this authority includes permission for removal of the brain and eyes, unless specifically exempted below, and that these examinations will not preclude viewing of the body. I also understand that The Children's Hospital of Philadelphia may share information about the deceased with other health care providers who were involved in the deceased's care and with outside labs and specialists to assist us in the performance of the autopsy. The nature of the autopsy examination and the condition in which the body will be delivered to the funeral director have been explained to me.

I assume responsibility to provide the services of a funeral director for the purpose of burial.

This authority shall be limited only by the following express conditions: (list restrictions for autopsy if any)

I certify that I have read and fully understand the above Consent and that all of my questions were answered to my satisfaction.

Signature of Consenting Party and
Relationship to Patient

Signature of Physician Obtaining Consent

Date/Time

Printed Name of Consenting Party

Printed Name of Physician

'Contact #

IF CONSENTING PARTY IS NOT AVAILABLE TO SIGN THIS FORM:
(Verbal Consent/Phone Consent)

Consenting Party's Name and
Relationship to Patient

Means of Obtaining Oral Consent

Date/Time

Signature of Witness to Oral Consent

Signature of Physician Obtaining Oral Consent

Printed Name of Witness to Oral Consent

Printed Name of Physician

Contact #

Authorization for Release of Remains From The Children's Hospital of Philadelphia

We, _____,
(Next of Kin, first and last name, printed)

Hereby authorize The Children's Hospital of Philadelphia to release the remains of:

(Patient, first and last name, printed)

To: _____
(Funeral Home/Transportation Service)

Funeral Home/Transportation Service Phone: _____

Authorized by: _____ Phone: _____
(Person completing form, first and last name, printed)



MR-109
Rev. 3/21

**AUTHORIZATION TO RELEASE/OBTAIN
PATIENT INFORMATION**

Page 1 of 1

LAST NAME

FIRST NAME

MR#

DOB

PLACE PATIENT LABEL HERE OR COMPLETE ABOVE

DO NOT HANDWRITE PATIENT INFORMATION HERE

This authorizes Children's Hospital of Philadelphia and its affiliates to release/obtain information as described below. For a listing of related entities and medical practices, see Children's Hospital of Philadelphia Notice of Privacy Practices.

1. **Patient Name (First, Middle, Last):** _____
Address of Patient: _____
City, State, Zip: _____
Telephone Number: _____ **Date of Birth:** _____
2. **What is the name of the person or facility that will be releasing your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
 Children's Hospital of Philadelphia or **Other**
Name of Person / Facility: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____ Fax Number: _____
3. **What information will be released?** Date of appointment or hospital stay beginning _____ through to _____
 Emergency Department **Home Care** **Outpatient** _____
 Inpatient **Immunization** (please specify name of department/office)
 Other Information (please specify) _____
If there is any part of the record you do not wish released, please indicate here: _____
If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
Drug and/or alcohol treatment or testing _____ **HIV** _____ **Mental Health** _____
4. **Medical Record delivery format:** If no selection is made, default will be Paper.
 Paper **CD** **MyCHOP** (active account needed) **Fax** **Other** _____
5. **What is the name of the person or facility who is to receive your information?** Check the appropriate box below and provide the name, address and telephone number of the person/facility releasing the information.
 Children's Hospital of Philadelphia or **Other**
Name of Person / Facility: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____ Fax Number: _____
6. **Please explain why the person or facility above needs this information:**

7. **Expiration.** Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when your permission expires. The date cannot be more than a year from now: _____.
8. **Understanding this Authorization**
 - This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.
 - I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by Children's Hospital of Philadelphia, see its Notice of Privacy Practices for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission, any information that was already released cannot be retrieved.
 - Information released by Children's Hospital of Philadelphia may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. Children's Hospital of Philadelphia will protect information it obtains as required by federal privacy laws.
 - I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.
9. **Signature.** By signing, I understand that I am authorizing Children's Hospital of Philadelphia to release/obtain information as described above.

Signature

Printed Name

Date

Time

Relationship to patient: Patient Parent Legal Guardian Other: _____

Information Released by: _____ Date: _____

WHITE – MEDICAL RECORDS

YELLOW – PATIENT/PARENT/LEGAL GUARDIAN

The Children's Hospital of Philadelphia

Pediatric & Perinatal Autopsy Consult Service Expectations

- Prior to commencement of services, all clients are required to identify the following:
 - A **physician contact** (pathologist or clinician, preferably medical director or equivalent) who will be responsible for medical oversight of procedures/protocols at their institution to meet CHOP's consult service expectations.
 - An **administrative director contact** (or equivalent) who will be responsible for administrative oversight of procedures/protocols at their institution to meet CHOP's consult service expectations, and including but not limited to billing, reconciliation of charges, documentation, and transport.
 - A **Courier Service** or **Funeral Home** to be routinely used for transport of remains from the client's institution to CHOP.
- Bodies for autopsy received without meeting the requirements outlined below may be delayed or returned.
 - If requesting an autopsy on a case that does not meet these requirements, prior approval by the CHOP Director of Autopsy or the Anatomic Pathology Operations Director is required prior to transport to CHOP.
- Unacceptable/declination criteria:
 - Patient >18 years of age at the time of death
 - Non-natural event in the cause of death sequence or obvious litigious intent
 - Embalmed or formalin-fixed decedents
 - Number of days from death or delivery (if stillborn) to autopsy > 7 calendar days
- CHOP Pathology must be called at 215-590-1728 to notify of intent to send body and request autopsy
- All the following forms/documents must be accurately and entirely completed:
 - CHOP **Autopsy Request Checklist**
 - CHOP **Authorization for Autopsy**
 - Outside hospital autopsy consent forms are not accepted.
 - Any autopsy restrictions must be clearly specified on the **Authorization for Autopsy** form.
 - Signature by one parent is acceptable if there is only one legal parent or both parents agree but one is unable to sign.
 - Permission by telephone is acceptable only if consent is witnessed by a physician or advanced practice provider and another person.
 - Form must be entirely completed to be rendered valid.
 - CHOP **Authorization for Release of Remains from The Children's Hospital of Philadelphia**
 - Must clearly state the decedent's name.
 - If releasing the body to a funeral home, the name and phone number of the funeral home are required.
 - If releasing to a courier service, the name and phone number of the service are required.

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- Completed forms and relevant medical records must be transmitted to CHOP Pathology via fax or email, and accompany the body as follows:
 - For stillborn/fetal demise cases, please send the following:
 - Maternal History and Physical
 - Maternal delivery note
 - Any available prenatal records
 - Prenatal genetic testing results, if performed
 - For liveborn/infant cases, please send the following:
 - Infant deceased discharge note
 - Infant admission/history and physical note
 - Maternal delivery note, admission/history and physical, and prenatal records, if available
 - Pre- or postnatal genetic testing results, if performed
 - Transmit electronic copies of forms/records either by fax to 215-590-1736 or by secure email to chopapconsult@chop.edu.
 - Send paper records/forms with the decedent to CHOP.
- Transportation of the body/remains:
 - The referring institution is responsible for arranging transportation of the body to CHOP via a licensed courier service or funeral home.
 - All fees associated with the transportation are the responsibility of the outside hospital.
 - Body must be kept fresh and refrigerated at all times (not frozen or in fixative).
 - Ensure body is properly identified:
 - Wristband or toe tag must be attached to body and include two identifiers.
 - In the case of stillborn/fetus, mother's name and one other identifier should be included.
 - Upon completion of the autopsy:
 - CHOP staff will contact the funeral home or courier service provided for transport.
 - In the event that a courier service or funeral home is not specified for release of remains after completion of consultation autopsy services at CHOP, CHOP Pathology will return all remains to the client one week after autopsy gross exam completion via the client's courier at the client's expense.
 - CHOP is not responsible for disposal of remains.
- Request for placentas associated with fetus/infant (up to 1 month old):
 - The placenta should accompany the body to CHOP for examination.
 - If delivery took place at a different institution, please complete the Children's Hospital of Philadelphia **Authorization to Release/Obtain Patient Information** form with appropriate signature.
 - Requirements for placenta transport:
 - Placenta should be kept fresh and refrigerated prior to transport (will also be accepted in fixative).
 - Placenta should be labeled with the mother's information, including at least name and maternal date of birth.
 - If the placenta is already processed, please send report, blocks, slides, and residual wet tissue (if available).
 - The placenta will be accessioned as a consult surgical specimen, processed, and charged appropriately.
 - If the placenta was or is being examined and reported by the client, it will be examined at CHOP and charged as a CPT 88325 surgical consult-comprehensive.
 - If the placenta was not already examined, it will be charged as a surgical specimen examination, either CPT 88307 (placenta, third trimester) or 88305 (placenta, other than third trimester).

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- Autopsies are performed Monday – Friday, 9 am to 5 pm.
- Retention of materials:
 - Organs will be retained and disposed of following CAP regulations and not returned with the body, unless specifically noted as a restriction on the CHOP Authorization for Autopsy form.
 - If organs are to be returned to the body, neuropathologic examination (brain and spinal cord) will not be performed.
 - Representative portions of organs (and placenta, if available), may be snap frozen and retained following institutional guidelines for possible future testing and are available upon request.
- Autopsy reports:
 - Preliminary autopsy reports are completed within 4 working days of autopsy initiation, per CAP guidelines.
 - Final autopsy reports are completed within 60 working days of autopsy initiation, per CAP guidelines.
- Ancillary testing:
 - Radiographs are routinely performed on fetuses and neonates at no additional charge.
 - Routine bacterial and fungal cultures, if indicated, will be performed at no additional charge.
 - Genetic testing can be performed upon request for additional fees and with a separate genetic testing order.
 - Additional immunostains and special stains may be performed depending on the initial histologic findings of the case. These charges are not included in the base autopsy fee and will be detailed separately.
- Communication with decedent's relatives:
 - All communication with the family of the decedent regarding transportation, autopsy process and reports, and release of body are the responsibility of the referring institution. Do not direct patient families or relatives to call CHOP. If contacted by decedent's family, CHOP will direct them to call the referring institution to obtain the desired information and answer questions.
 - All questions and concerns of patient families should be communicated through the outside clinician or staff to CHOP Pathology.
 - We do not release pathology records/reports to patient families.
 - If there are any questions or concerns regarding the performance or status of the autopsy, pathology reports, or location of remains, the referring institution staff can call CHOP Pathology to obtain this information.
 - It is the responsibility of the referring institution/department to release the autopsy and associated reports to the patient's medical record, clinicians, and family members.
 - If the referring institution has not received reports or have questions about reports, please call or email to inquire about the status.
 - CHOP pathologists may contact the ordering clinicians to obtain additional information to assist with the performance and interpretation of the autopsy findings. These clinicians may contact our department to discuss the autopsy results with the pathologist of record.
- Third-party billing:
 - CHOP Pathology does not perform third-party billing.
 - All bills generated for services rendered are submitted to the outside client for payment.