



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. _____/_____/_____	M.O.	
ADDRESS		
LOCATION / WARD		

Facility:

### NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

#### ?CJD BRAIN EXAMINATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

For all public hospital inpatients you must complete the NSW Coronial Checklist (SMR010.513 NH606536).  
Have you completed this checklist  Yes  No

[Note: This form should be used to obtain consent for the conduct of a non-Coronial post mortem. A copy of the completed form must be (1) retained as part of the post mortem record; (2) placed in the deceased person's health record; and (3) given to the person who provided consent i.e. the senior available next of kin or their delegate].

#### SECTION 1 (Patient's Doctor to Complete)

##### DETAILS OF PERSON OBTAINING CONSENT

Family name \_\_\_\_\_ Given name \_\_\_\_\_

Institution/Hospital \_\_\_\_\_

Person's Position \_\_\_\_\_

Contact Telephone \_\_\_\_\_ Pager \_\_\_\_\_

##### ADDITIONAL DETAILS OF THE DECEASED

Date of death \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (Leave blank for pre-mortem consent)

Optional: Is the deceased an Aboriginal person or Torres Strait Islander? [Tick relevant box]

- YES
- NO
- UNKNOWN

#### SECTION 2: PERSON GIVING THE CONSENT

[Tick relevant box and complete as appropriate]

**NOT APPLICABLE FOR CJD**

~~PERSON GIVING THEIR CONSENT DURING THEIR LIFE TIME TO A POST MORTEM EXAMINATION OF THEIR BODY AFTER DEATH~~

~~I, \_\_\_\_\_ [insert name] consent to a post mortem examination of my body after I have died as detailed in Section 3.~~

**SENIOR AVAILABLE NEXT OF KIN (Enduring Guardian and Power of Attorney not applicable)**

##### DETAILS OF SENIOR AVAILABLE NEXT OF KIN

Family name \_\_\_\_\_ Given name \_\_\_\_\_

of \_\_\_\_\_ [Insert address]

Relationship of senior available next of kinto deceased: \_\_\_\_\_

of \_\_\_\_\_ [Insert address and postcode]

~~A DELEGATE OF THE SENIOR AVAILABLE NEXT OF KIN~~

**NOT APPLICABLE FOR CJD**

##### DETAILS OF DELEGATE OF THE SENIOR AVAILABLE NEXT OF KIN

Family name \_\_\_\_\_ Given name \_\_\_\_\_

of \_\_\_\_\_ [Insert address and postcode]

Telephone \_\_\_\_\_

Attach written authorisation of delegate

#### SECTION 3: THE CONSENT

I CONSENT TO THE FOLLOWING BEING CARRIED OUT ON THE ABOVE NAMED DECEASED: [Tick relevant box]

- a full post mortem examination of the deceased
- a post mortem examination of the deceased **LIMITED** to the following organs, body parts or body cavities:

**Brain (CJD autopsies are brain only)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



SMR020032

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

SMR020.032

NH606698 250518

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D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		

Facility: \_\_\_\_\_

**NON-CORONIAL POST MORTEM  
CONSENT & AUTHORISATION**

**?CJD BRAIN EXAMINATION**

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

I ALSO CONSENT TO: *[Tick relevant box]*

The retention of organs and other body parts for diagnostic testing.  
The following organs or body parts **CAN** be retained Brain

**Optional:** The retention of organs and other body parts for scientific, therapeutic and medical purposes.  
The following organs or body parts **CAN** be retained Brain

The retention of \_\_\_\_\_ *[Specify organs or body parts]*  
for \_\_\_\_\_ *[Specify research study]*

I REQUEST that any organs and other body parts be: *[Tick relevant box]*

- Reunited with the body prior to burial/cremation;
- Returned to me or the person nominated by me, if practicable  
Name of nominated person \_\_\_\_\_  
Address of nominated person \_\_\_\_\_  
Relationship to nominated person \_\_\_\_\_
- Disposed of in a lawful manner by the hospital

**Reports** It is recommended that the post mortem report be discussed with a clinical specialist or nominated GP.

I request that:

**(Nominated GP Details)**

a copy of the post mortem report be sent to \_\_\_\_\_  
Address \_\_\_\_\_

The body is ready for the funeral which takes place: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_:\_\_\_\_

**FUNERAL DIRECTOR:** Name \_\_\_\_\_ Contact number \_\_\_\_\_

I HAVE NO REASON TO BELIEVE that the deceased had expressed any objection to this post mortem examination or any use of tissue noted above.

**THE NATURE OF THE POST MORTEM EXAMINATION** and the way in which the tissue from the deceased's body will be dealt with have been explained to me.

I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

**SIGNATURE** of the person giving consent in their lifetime \_\_\_\_\_

**SIGNATURE** of the senior available next of kin or authorised delegate \_\_\_\_\_

**SIGNATURE** of doctor/health professional \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

INTERPRETER present:  NO  YES \_\_\_\_\_  
*[ Full name of Interpreter] [Signature of Interpreter]*

**AUTHORISATION BY A DESIGNATED OFFICER (Not Treating Doctor)**

I, \_\_\_\_\_ hereby authorise: *[Tick relevant box]*  
*[Full name of Designated Officer]*

- the full post mortem examination of the deceased's body
- the limited post mortem examination of the deceased's body
- the retention of organs or other body parts for diagnostic testing
- Optional:** the retention of tissue, organs and body parts removed for the purposes of the post-mortem examination for scientific, therapeutic, and medical purposes as set out in the above consent.

I, \_\_\_\_\_ declare that I do not have a personal interest in the deceased and I have not had a clinical involvement with the deceased.  
*[Name of the Designated Officer]*

**SIGNATURE** of the Designated Officer \_\_\_\_\_

**DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

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BINDING MARGIN - NO WRITING

