



University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

TGH TWH PMH

CONSENT FOR AUTOPSY

SEE OTHER SIDE FOR CONSENT FOR USE OF TISSUE, BLOOD AND BODY FLUIDS OBTAINED AT AUTOPSY

Other _____

Addressograph

ONLY THE FOLLOWING ARE AUTHORIZED TO GIVE CONSENT FOR AN AUTOPSY:

- 1) The Executor of the Estate. **The Executor should be familiar with the patient's wishes.** or, if not known;
- 2) a spouse of any age (see note below);
- 3) if none, any of the children who have attained the age of 16 yrs., or;
- 4) if none, either parent or;
- 5) if none, any brother or sister who has attained the age of 16 yrs., or;
- 6) if none, any of the next-of-kin who has attained the age of 16 yrs., or;
- 7) if none, the person lawfully in possession of the body. (THIS IS NOT THE HOSPITAL).

NO UNIVERSITY HEALTH NETWORK STAFF PHYSICIAN, HOSPITAL EMPLOYEE OR ADMINISTRATOR MAY GIVE CONSENT FOR AN AUTOPSY (Exceptions at left)

(THE ORDER OF PRIORITY LISTED ABOVE MUST BE STRICTLY FOLLOWED)

SPOUSE means a person of the opposite sex:

- a) to whom the person is married; or
- b) with whom the person is living, or immediately prior to death, was living in a conjugal relationship outside marriage, if they: i) have cohabitated for at least one year; ii) are together the parents of a child; or iii) have together entered into a cohabitation agreement under Sec. 53 of the Family Law Act.

I, _____, as the _____

(Print Name)

(Relationship/Capacity)

of the late _____ hereby consent to and authorize an autopsy

(Name of deceased)

on the body of the deceased, including the removal, use and disposal of any organs or tissues.

IF PERSON SIGNING IS NOT THE EXECUTOR OR SPOUSE, EXPLAIN BELOW.

SPECIFIC INSTRUCTIONS/RESTRICTIONS, (if any):

Date the _____ day of _____ year _____ . Signed _____

Address: _____ Tel #: () _____

NOTE: PLEASE CHECK APPROPRIATENESS OF PERSON GIVING CONSENT

Witness's Name _____
(PLEASE SIGN AND PRINT NAME)

(A second witness is necessary for a telephone consent)
(SIGN AND PRINT NAME)

Coroner's Case: Coroner notified Yes No

Body release by Coroner Yes No

In Person

Body released by Coroner Yes No

By Telephone

Signature of Coroner (If Present)

Name of Coroner (If Not Present)



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CONSENT FOR USE OF TISSUE, BLOOD AND BODY FLUIDS OBTAINED AT AUTOPSY, FOR FUTURE RESEARCH

Addressograph

The University Health Network is an academic institution that conducts medical research on tissues, blood and body fluids in order to learn more about what causes disease, how to prevent them, how to treat them and how to cure them. We are seeking your permission to store samples of any excess tissue, blood or body fluids for future research purposes. Any future research that may be carried out on the tissues, blood or body fluids of the deceased will be both scientifically and ethically reviewed and approved by the University Health Network's Research Ethics Board.

I understand that samples from the above named may be stored indefinitely. Only coded identifiers will be kept with the sample and the link between that coded identifier and the deceased will be kept in a separate secure and confidential facility. None of the research results will be placed in the deceased's record unless I give explicit permission in the future for the results to be released.

I understand that research carried out on these samples by researchers at the University Health Network, or their collaborators, may lead to the development of marketable treatments, devices, new drugs or patentable procedures. I understand that neither I nor the estate of the deceased will benefit from such commercial developments and that any benefit from commercial products will remain with the University Health Network and their partners.

I understand that there is a possibility that these samples may be used for genetic research (research about diseases that are passed on in families), and that the results will not be put in the deceased's health records.

In the event that researchers wish other information about the above named for future research, I give my permission for researchers from this institution to contact me, or in my absence, the next of kin of the deceased.

YES NO

I understand that I am voluntarily releasing samples of tissue, blood or body fluids of the deceased for research purposes. I understand that I have the right to refuse to allow such research studies on these tissues. I further understand that I can have the sample(s) removed from storage and have them destroyed at any time in the future by contacting the Research Ethics Board at the University Health Network.

I certify that the above statements have been fully explained to me, that I have had any questions answered to my satisfaction, and that the doctor has explained to me that tissues, blood or body fluids of the deceased, may be saved for future research and that this will not affect the process of post mortem examination, in any way.

I, _____, as the _____ of the late _____
(Print Name) (Relationship/Capacity) (Name of deceased)

agree, that tissue, blood or other body fluids from the deceased may be used for future research.

Date

Signature of Next of Kin/Executor of Estate

Date

Name of Witness

Signature of Witness to Signature