Your Hospital's Logo Here

DISPOSITION INSTRUCTIONS & PERMISSION

PATIENT IDENTIFICATION

(FETUS, STILLBORN OR EXPIRED LIVEBORN WEIGHING < 500 GRAMS)

MOTHER'S FULL NAME:	HOSPITAL #:	DATE:

I. (CHECK ONE)

☐ I will be fully responsible for making funeral arrangements within seven (7) calendar days. I will communicate these arrangements to the Admitting Office at this Hospital. I understand that after seven (7) calendar days, this Hospital will have to assume responsibility for the disposition of the remains of my infant and that this will be by cremation by a registered funeral home.

☐ I hereby request this Hospital to care for the remains of my infant. I understand that this will be done via cremation by a registered funeral home.

SIGNATURE

WITNESS

SIGNATURE of Receiving FUNERAL DIRECTOR

II. IF PATIENT IS UNABLE TO CONSENT (or) IS LEGALLY INELIGIBLE, COMPLETE SECTION BELOW.

PATIENT UNABLE TO CONSENT BECAUSE:		
SIGNATURE OF NEXT OF KIN / LEGAL GUARDIAN:	WITNESS:	DATE:

WHITE ORIGINAL - Admitting Office **YELLOW COPY - Admitting Office**

Admitting Office INSTRUCTIONS: After Funeral Director signs, forward WHITE ORIGINAL to Medical Records. Forward YELLOW COPY to Funeral Director.

PART OF THE MEDICAL RECORD