CJD Post mortem examination form used when referring cases to the coroner (FORM C).

Beaumont Hospital
Coroner Autopsy Information Form

(may be used when referring cases to the Coroner for CJD Post Mortem Examination)
This is not a consent form

The Coroner may order that a post mortem be performed on the body of ______________________
If this is the case, consent from the next of kin is not an option as the Coroner may, under the law, order a post mortem in certain situations to establish or clarify the cause of death. A post mortem involves the removal and detailed examination of the deceased brain. It is usual for the brain to be retained during the procedure and for small samples of tissue to be taken for microscopic examination.

PRE CORONER'S DECISION REGARDING POST MORTEM

I confirm that:

- I understand that the option for my consent does not arise for a Coroner's post mortem examination ☐
- I have been informed the reason why this death was reportable to the Coroner. ☐
- I have been informed that tissue and organ will be retained during the post mortem for further diagnostic examination ☐

PLEASE READ THE OPTIONS GIVEN BELOW CAREFULLY

- I agree that a member of Beaumont Hospital Staff will contact me following the post mortem examination to provide advice and on-going information regarding organ retention. ☐

OR

- I do not want the hospital to make any further contact with me in relation to the organ retention.
- In declining contact I am informed that the retained organs will be respectfully disposed of by Beaumont Hospital and agree to complete the Glasnevin Trust Cremation form (EX-NEU-0559). ☐

Signed:______________________Date: DD / MM / YYYY Relation to deceased:_____________
(Nominated family member)
Contact Number: (Mobile)__________________________(Home)________________________

NAME (PLEASE PRINT):____

Address: ____

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I confirm that I have explained the Coroner's Post Mortem procedure and the possibility of organ retention
to the nominated family member.

Signed:______________________Date: DD / MM / YYYY Contact Number:_________________
(Health Care Professional)
NAME (PLEASE PRINT):____

The signed copy of this form is to be retained by Beaumont Hospital designated social worker.