Autopsy clinical summary form

Please attach the following:

- *copy of the death certificate*
- *copies of all antenatal ultrasound reports, and*
- *copy of amniocentesis report if available*

Maternal sticker
(Inc Name, DOB, UR, Address, Telephone number)

◯ **Singleton** ◯ **Multiple** **Baby #:** e.g. Twin 1

Baby details

a. **UR Number:**

b. **Sex**
◯ Male ◯ Female ◯ Undetermined

c. **Gestational age:** weeks / days

d. **Birthweight:** g

e. **Date & Time of Birth:** / / :

f. **Place of Birth:**

g. **Type of Death:**
◯ Fetal
a. **Antepartum Death**
◯ Unknown ◯ No
◯ Yes, estimated date of death: / /
◯ Neonatal (NND)
a. NND Date & Time of Death: / / :

h. **Death Certificate completed**
◯ Yes ◯ No

Autopsy Hazard

a. **Treatment or condition likely to cause hazard at autopsy:**
◯ Hepatitis B Pos ◯ Tuberculosis
◯ HIV (AIDS Virus)
◯ Other ***(please describe)***

Clinical summary *(including details to be clarified at autopsy)*

Provisional clinical diagnosis *(to be completed by physician requesting autopsy)*

1.
2.
3.
4.

Please list doctors to receive report

Name	Address
1.	
2.	

Consultant:

Clinical Contact:

Signature: (person completing this form)

Print Name:

Telephone:

Pager:

Date: / /