VirginiaAutopsyServices.com

Virginia Pathology and Autopsy Services
P.O. Box 304, Locust Grove, VA 22508
Office: (540) 935-1146 or (703) 725-7979
Fax:(540) 227-7387 Email: VirginiaAutopsyServices@gmail.com

Request and Authorization for Autopsy

Please Print Clearly

I. The Deceased:

Name: _____DOB:_____ Age: _____ Sex: ❒M ❒F

Date of Death:_____ Time of Death:_____ Location of Death Pronounced: _____

II. The Party Requesting the Autopsy:

Name:_____ Relationship to Deceased:_____

Full Address:_____
City State Zip

Email:_____ Phone No._____

IMPORTANT:
I acknowledge that the deceased has been released by the State Medical Examiner either verbally or in writing and that the Medical Examiner has waived any jurisdiction in the case. **Initials**: _____

III. Consent to and Request for Autopsy:

I hereby authorize **Virginia Pathology and Autopsy Services**, Dr. Maritza Romero-Gutierrez or any other person or persons as it may designate, to perform an autopsy on the body of the above-named deceased. I warrant that I have the legal authority to give consent and to make this request. Organ specimens may be removed and retained for study subsequent to the autopsy which, in the judgment of the physician by whom it is performed, may be necessary to accomplish its purpose. Unless specifically limited, the autopsy request shall be a complete autopsy including head.

Limitations:

❒ None. (Complete autopsy) **Initials**: _____ ❒ Thorax and Abdomen Only **Initials**: _____

❒ Brain Only **Initials**: _____ ❒ Thorax and Brain Only **Initials**: _____

Was body embalmed? No ❒ Yes ❒

Blood Screening Toxicology Request: No ❒ Yes ❒ **Initials**:_____

After the autopsy, I direct the body to be released to Funeral Home Service Provider:

_____ **Will the body be cremated?** No ❒ Yes ❒

Note: Final autopsy report will be issue in approximately 8-10 weeks after autopsy is performed.

Signature (Person Authorizing Autopsy): _____ Date: _____

	Printed Name	Signature	Date
1st Witness:	_____	_____	_____
2nd Witness:	_____	_____	_____

Please fax this authorization to (540) 227-7387 or email to: VirginiaAutopsyServices@gmail.com

Payment is due at time of service by Check or Credit Card.
If paying by check, please make check payable to:
Maritza Romero-Gutierrez, MD and Associates, Inc., P.O. Box 304, Locust Grove, VA 22508

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Acceptance of Maritza Romero-Gutierrez, MD & Associates, Inc. Payment Policy

1) Autopsy Fees are due on the day of service prior to the scheduled time of autopsy.

2) Accepted forms of payment are Visa, MasterCard, American Express or Check. All credit card payments will be pre-approved prior to the time of service.

3) Transportation Fees are due at the time of service and are **not** included in the quoted autopsy fees. Transportation fees will still be the responsibility of the authorized signatory and in circumstances where the authorized signatory, or signatory's representative cancels the autopsy while the transportation company is in transit. This includes circumstances where transportation services are requested by signatory or signatory's representative but cancelled prior to or immediately before the actual time of autopsy.

Execution of this page constitutes a contract between Maritza Romero-Gutierrez, MD & Associates, Inc. dba Virginia Pathology and Autopsy Services and authorizing party.

Person Authorizing Autopsy:

Printed Name:_____

Signature:_____Date:_____

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Decedent Information

Name: _____ Date of Birth: _____

Age: ____ Sex: ❒M ❒F Ethnicity/Race_____

Is Hospital/Physician's Discharge Summary/Notes Available? ❒Yes ❒No

Date of Death: _____ Place of Death:_____

Immediate Next of Kin Name/Relationship to Deceased: _____

Clinical Medical History: _____

_____

_____

_____

_____

_____

_____

Was Deceased: Diabetic: ❒Yes ❒No ❒Not Known Smoker? ❒Yes ❒No _____

Hypertensive: ❒Yes ❒No ❒Not Known Approx. Weight: _____ Height: _____

Known Prescriptions: _____

_____

Events Immediately Prior to Death: _____

_____

_____

_____

_____

_____

_____