

CONSENT FORM FOR HISTOPATHOLOGICAL EXAMINATION AND DISPOSAL OF EARLY MISCARRIAGES ¹

1. PATIENT DETAILS

NAME: _____

DOB: _____

DATE OF EXAMINATION: _____

HOSPITAL: _____

WARD: _____

UNIT NO: _____

CONSULTANT: _____

GP: _____

GP's ADDRESS: _____

2. INFORMATION

A miscarriage is when a pregnancy ends in the early months. Although in many cases the cause will remain unknown it is important for the tissue from the pregnancy to be examined both visually and microscopically to look for abnormalities which might explain the miscarriage or affect future pregnancies.

In most cases this tissue, the products of conception, is made up only of the afterbirth (placenta), the lining of the womb (uterus) and blood clots. After visual examination tissue samples are made into blocks and slides for examination under a microscope.

Sometimes a tiny embryo or fetus, or fetal parts are found among the tissue. Examination of this can give valuable information. With your consent a pathological examination will be similar to that already described, but as the internal organs are very small they are placed whole into wax blocks and in some cases the entire body may be placed in the block.

- I confirm that I have read and understood the information given above and that any questions I have asked have been answered to my satisfaction and understanding.

3. CONSENT

A If fetal remains are identified visually:

- I do not wish any examination of the embryo/fetus/fetal parts to be carried out.
- I consent to the examination of the embryo/fetus/fetal parts.

and

- I wish the hospital to undertake cremation/burial of the fetal remains and unprocessed tissue and understand that the ashes cannot be returned to me.
- I wish to take the fetal remains and unprocessed tissue for family burial/cremation.

B If no fetal remains are identified visually:

- I wish the hospital to arrange cremation/burial of the unprocessed tissue and understand that the ashes cannot be returned to me.
- I wish to take the unprocessed tissue for burial/cremation.

4. CONFIRMATION OR REFUSAL OF CONSENT

Patient's signature:

Date: _____

Doctor/healthcare professional taking consent (print name):

Date: _____

Job title/grade: _____

Signature (of doctor taking consent):

¹ This form applies where any fetus present is below 12 week size (less than Crown Rump Length 6cm)



Department of
**Health, Social Services
and Public Safety**

An Roinn

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