Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Department of Pathology
4800 Sand Point Way NE
M/S FB.2.441
Seattle, WA, 98105

TEL: 206-987-2103
FAX: 206-987-3840

CONSULTATION AUTOPSY SERVICE
GENERAL INFORMATION FOR REFERRAL OF SPECIMENS

IN THIS PACKET:	1. General information face sheet 2. Consent form 3. Clinical history form 4. Authorization for autopsy payment 5. Cytogenetics service request 6. Authorization for ancillary studies payment 7. Additional paperwork request 8. Transportation policy
PRIOR TO SENDING A SPECIMEN:	Notify pathology **206-987-2103 (Monday – Friday, 8AM to 5PM; leave message after hours)**
CHECKLIST:	☐ Patient/parent or legal guardian has signed consent and indicated how disposition of the body will be handled ☐ Referring physician has completed the Clinical History form ☐ Indicate if cytogenetic (requires fresh tissue in transport medium) or array (can be performed with tissue obtained at autopsy) studies are desired ☐ Appropriate billing forms have been completed
MUST BE SENT TO SEATTLE CHILDREN'S:	1. Fetus AND placenta (unfixed, labeled, in sealed opaque containers) 2. Signed consent AND authorization for autopsy payment form **(Note that referring institutions, not families, will be billed directly for autopsy services)** 3. Clinical history form AND copies of pertinent prenatal records including prenatal imaging reports and delivery summary 4. Completed cytogenetics service request form AND authorization for ancillary studies payment form, if applicable
GENETIC TESTING INFORMATION:	For either karyotype or chromosomal SNP array, it is preferable for local institutions to obtain tissue samples and send them directly to the laboratory of their choice. As a second option for karyotype, tissue (e.g. skin or placenta) may be obtained at delivery, stored in transport medium, and sent to SCH. However, any delay in this procedure increases the risk of culture failure. Alternatively, tissue may be collected at SCH from the fetus or placenta for genomic SNP array analysis. Referring hospitals, not patients, will be billed separately for ancillary cytogenetic/array tests conducted at SCH.
TRANSPORTATION INFORMATION:	Refer to Transporting Fetuses and Neonates to Seattle Children's Hospital for Autopsy form. For fetuses under 20 weeks gestational age, a courier service may be used. Late gestational fetuses and surviving neonates should be sent by certified carrier (e.g., funeral director). Family transport is not permissible to-or-from Seattle Children's. **Seattle Children's Hospital is NOT responsible for arrangement of or payment for transport.**
ADDRESS FOR DRIVERS:	Clinical Laboratory (FB.2.441) Seattle Children's Hospital 4800 Sand Point Way NE Seattle, WA 98105
CONTACT INFORMATION:	Pathology Main Line: 206-987-2103 Pathology Fax: 206-987-3840 Pathologists' Assistant: 206-987-1803 Email: AutopsyService@seattlechildrens.org

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Patient Label

AUTOPSY CONSENT
CONSULTATION PATHOLOGY SERVICE

NAME OF PATIENT OR MOTHER:

DESCRIPTION OF SERVICE

The Consultation Pathology Service (CPS) at Seattle Children's Hospital provides anatomic and laboratory studies of a variety of specimens, including placentas, embryos, fetuses, and infants. Fetuses, infants, and other specimens sent to the CPS are examined by a board-certified pediatric pathologist with experience in placental, fetal, perinatal, and pediatric pathology. A complete examination, including review of the medical record, gross, microscopic, imaging, and laboratory studies as indicated, is performed and a detailed report issued to the referring physician. **Preliminary report turnaround time is 2 business days and final report turnaround time is 30 business days from the date of autopsy.** Confidentiality is maintained at all times in accordance with institutional, state, and federal policies and regulations.

HANDLING OF REMAINS

For all fetuses and infants **older than 20 weeks gestational age** (menstrual dating based on clinical assessments):	Parent(s) MUST arrange for a funeral service to pick up the remains from Seattle Children's Hospital. Specify funeral service: _____ _____
For all fetuses **less than 20 weeks gestational age** (select one):	☐ SCH will handle cremation. The ashes will NOT be returned to the parents. ☐ Parent(s) will arrange for a private funeral service to pickup the remains from SCH. Specify funeral service: _____ _____

PARENTAL CONSENT

The undersigned gives permission for a complete pathological examination, including removal and retention of any tissues for diagnostic or scientific purposes, with privilege of ultimate disposal of such tissues, as the physicians in attendance at the Seattle Children's Hospital deem desirable.

Parent Signature _____ _____
Date

Witness Signature _____ _____
Signature Print name of witness

RESTRICTIONS OR SPECIAL INSTRUCTIONS:

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CLINICAL HISTORY FORM
CONSULTATION PATHOLOGY SERVICE

Seattle Children's Hospital
4800 Sand Point Way NE M/S FB.2.441 Seattle, WA 98105
Telephone: (206) 987-2103 | FAX: (206) 987-3840

Patient Label

MUST BE COMPLETED BY REFERRING PHYSICIAN

Mother's name _____

Mother's DOB / MRN _____

Baby's name (if applicable) _____

Baby's MRN (if applicable) _____

Delivering hospital _____

Referring physician Name _____

(contact for questions) Fax: _____ Phone:_____

Date of delivery_____ Time of delivery_____ Estimated gestational age _____

Mother: Age _____ Race _____ LMP _____

Gravida _____ Para _____ SAb (1st trim) _____ TAb _____
SAb (2nd trim) _____
SAb (3rd trim) _____

Circle / Check as appropriate

1. Mode of delivery: Labor induction

   ☐ fetus alive at time of induction

   ☐ after spontaneous intrauterine demise

   ☐ after KCl-induced intrauterine demise

   Spontaneous vaginal delivery

   C-section

   D&E / D&C

2 Liveborn: Yes No If yes, date/time of death: _____

3. Prenatal ultrasound: Yes No If yes, where? _____
4. Placenta (sent to): With fetus. With family. Discarded. Pathology laboratory _____
5. Cytogenetics / Array Completed. Laboratory _____

   Tissue submitted, result pending. Laboratory _____

   Obtain tissue at autopsy for karyotype/array testing at SCH (additional charge)

   Do not obtain tissue for karyotype / array

6. Pregnancy History (include exposures, abnormal laboratory or ultrasound findings, medical or delivery complications, family history). Please summarize and attach patient records / documentation.

7. In addition to referring physician, send additional pathology reports to (include fax, phone, and email)

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AUTHORIZATION FOR AUTOPSY SERVICES PAYMENT

FORM INSTRUCTIONS

1. All fields below MUST be completed
2. This form MUST accompany the Autopsy Consent – Consultation Pathology Service form
3. The requesting institution will be billed by SCH and the institution will be responsible for covering payment. Seattle Children's does NOT bill families or their insurance providers for autopsy services.
4. Flat rate cost of fetal autopsy consultation is $1500 (excluding additional ancillary studies), please call SCH Pathology (206-987-2103) if you have any additional questions

BILLING INFORMATION

Referring Institution:	
Referring Physician:	

This document serves as attestation that the above-named **Institution** will be responsible for payment to Seattle Children's Hospital for the autopsy and any additional ancillary testing performed on the fetus/infant/child of:

_____ who died on _____.
(mother's name) (date)

REQUESTOR INFORMATION

Representative of Responsible Party (Name of Person Filling Out Form):	
Title/Position:	
Contact Number:	
Date:	

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AUTHORIZATION FOR ADDITIONAL ANCILLARY STUDIES PAYMENT

FORM INSTRUCTIONS

1. If the family/physician declines additional testing, the Cytogenetics Service Request form and Authorization for Additional Ancillary Studies Payment form may be disregarded
2. If the family/physician requests additional testing, all fields below MUST be completed
3. This form MUST accompany the Cytogenetics Service Request form if additional ancillary testing is requested to be performed at Seattle Children's Hospital
4. Additional ancillary studies paperwork does NOT have to be filled out prior to the autopsy; the family/physician may decide on additional testing later at which SCH will fax forms to the requesting institution
5. The Referring Institution, NOT the family, will be responsible for payment.
6. Cost is dependent on the requested study, please call SCH Pathology (206-987-2103) if you have additional questions

BILLING INFORMATION

Referring Institution:	
Referring Institution Billing Address:	
Referring Institution AP Cost Center:	
Referring Physician:	

This document serves as attestation that the above-named **Institution** will be responsible for payment to Seattle Children's Hospital for any additional ancillary testing performed on the fetus/infant/child of:

_____ who died on _____.
(mother's name) (date)

REQUESTOR INFORMATION

Representative of Responsible Party (Name of Person Filling Out Form):	
Title/Position:	
Contact Number:	
Date:	

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REQUIRED RECORDS FOR AUTOPSY REVIEW

The following additional records/paperwork are required for autopsy review (check boxes):
☐ Delivery summary ☐ Expiration summary ☐ Pertinent pre/perinatal medical records, including relevant laboratory testing/results (mother AND infant – if liveborn) ☐ Pertinent prenatal imaging reports (ultrasound, MRI, etc.) ☐ If this is a neonatal patient and the placenta has already been examined, a copy of the pathology report ☐ Patient demographic face sheet

Records are sent:
☐ Hardcopy with baby/placenta ☐ Faxed to Seattle Children's Pathology (206-987-3840)

If records are unavailable, please state the reason and contact information:
Reason for unavailable records:
Name/Title:
Contact Information:

Per the Health Insurance Portability and Accountability Act (HIPAA), autopsy consultation is considered continuity of care. A Release of Information (ROI) form is NOT required for access of these records. The HIPAA Privacy Rule permits a health care provider to disclose protected health information about an individual, without the individual's authorization, to another health care provider for that provider's treatment of the individual. See signed Autopsy Consent form for parental authorization to a complete examination including review of medical record, gross, microscopic, imaging, and laboratory studies. Confidentiality is maintained at all times in accordance with institutional, state, and federal policies and regulations.

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Transporting Fetuses and Neonates to Seattle Children's Hospital for Autopsy

FETUSES YOUNGER THAN 20 WEEKS GESTATION

Legally, these fetuses are classified as non-viable and can be transported as surgical specimens. Fetuses must be wrapped in a moist towel to prevent dehydration and placed on cold packs for shipping via local courier or overnight express service. All wrapping must be thorough to prevent leakage and labeling must be done in a discrete manner.

If delays are anticipated during shipping, the body may be fixed in formalin (in the normal anatomic position to avoid positional artifacts) prior to transport. Small incisions in the abdomen and scalp will assist fixation. Formalin is toxic, so quantities must be minimal and identified with the carrier.

No legal documentation (death certificate, transit/burial permit) is required for stillbirths under 20 weeks gestation. A standard electronic death certificate (EDRS) is required for livebirths under 20 weeks gestation. An autopsy permit, complete medical history including prenatal records, prenatal imaging reports, delivery summary, and documentation of the family's wishes for disposition of remains are required. Appropriate forms are available from the Fetal Pathology Service at Seattle Children's.

For fetuses younger than 20 weeks, families must arrange for disposition, or we can arrange for cremation.
However, ashes are not retained or returned to the family.

FETUSES OLDER THAN 20 WEEKS GESTATION

A fetal death certificate (for stillborns) or standard electronic death certificate on EDRS (for those born alive) is required. (Physicians may write "pending autopsy" in place of diagnosis if they desire.) The fetal death certificate must accompany the body but does not need to be visible on the outside of the package; in fact, we encourage discretion in this matter.

Late gestational fetuses / neonates must be transported by certified human transport service (i.e., First Call Plus or local funeral home) rather than the postal or express postal service. Arrangements can be made locally or coordinated through a funeral home, but the cost must be born by the referring institution or family.

Packing must be done with extreme care, so that no leakage occurs during transit. The body should be packed in absorbent material and a minimum of three heavy plastic, sealed bags. The entire package must be sealed in a heavy cardboard box of adequate size, to avoid positional artifacts.

For fetuses older than 20 weeks, families must arrange for disposition after autopsy.

Shipping address:

Seattle Children's Hospital
Clinical Laboratory (Mailstop FB.2.441)
4800 Sand Point Way NE
Seattle WA 98105
Phone: (206) 987-2103
Fax: (206) 987-3840

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Cytogenetics Services Request

Department of Laboratories
4800 Sand Point Way NE OC.8.720
Seattle, WA 98105 (206) 987-2102
http://seattlechildrenslab.testcatalog.org

FAILURE TO COMPLETE MAY DELAY RESULTS

Patient's Last Name	First	Middle	**Birth date (required)**	Sex

Outside Patient Number	Outside Specimen Number	Send Report To:
Ordering Provider		Address:
Provider Phone Number	**DIAGNOSIS / ICD CODE:**	Phone/Fax #:

*****REQUIRED INFORMATION***:**
Healthcare professional to call for information/abnormal results: **NAME** (please print): _____ **PHONE#:**

SPECIMEN INFORMATION: Date collected: / / Whole Blood: ☐ Na Heparin ☐ EDTA
Time collected: _____ ☑ Other (tissue / fibroblast): _____

PERIPHERAL BLOOD

CH-SNP ☐ Single Nucleotide Polymorphism (SNP) Array

CH-KARY ☐ Peripheral blood karyotype for _____
☐ Peripheral blood karyotype + R/O mosaicism for _____
☐ Workup for Turner Syndrome
☐ Sex determination/ambiguous genitalia (includes 10 metaphase cells by SRY FISH + 20 metaphase cells by G-bands)

CH-FISH ☐ Fluorescence *in situ* hybridization (FISH)
☐ Velocardiofacial (VCF)/DiGeorge Syndrome
22q11.2 deletion/duplication syndrome
☐ Williams Syndrome
☐ Other: _____

CH-FAMS ☐ Family follow-up study (all information is **required**)
Proband name: _____
Relationship to Proband (please provide pedigree): _____
Test indicated on Proband report: ☐ Limited Karyotype
☐ FISH ☐ SNP Array ☐ qPCR

TISSUE

CH-SKIN ☐ Solid Tissue - Fibroblast culture ONLY
CH-SKIN ☐ Solid Tissue - Fibroblast culture + Karyotype
CH-POC ☐ Tissue - Products of Conception
☐ SNP Array
☐ FISH_____ (specify target)

CLINICAL FINDINGS & FAMILY HISTORY

Please include either Diagnosis/ICD-9 Code and/or Clinical Findings for all Cytogenetic testing

_____
_____
_____

(open space for pedigree)