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DEATH CERTIFICATES GENERAL INFORMATION

1. MUST BE COMPLETED IN BLACK INK

2. PLEASE USE OVERLAYS TO ASSIST WITH COMPLETING DEATH CERTIFICATES WHICH ARE AVAILABLE ON ALL FLOORS

3. COMPLETE **ONLY** LINES 23A-32 **WITH THE EXCEPTION OF LINES 30A-30F WHICH ARE TO BE COMPLETED BY A MEDICAL EXAMINER ONLY**

4. LINES 31A,B,C AND LINE 32 MUST BE COMPLETED BY THE SAME PHYSICIAN AND THE PHYSICIAN MUST BE LICENSED IN THE STATE OF WV

5. **DEATHS THAT HAVE TO BE REFERRED TO THE MEDICAL EXAMINER:**
    - ALL DEATHS THAT ARE NOT CONSIDERED NATURAL
    - ALL DEATHS DURING INCARCERATION
    - ALL DEATHS OF PATIENTS WHO ARE A WARD OF THE STATE

PLEASE SEE THE FOLLOWING PAGE FOR AN EXAMPLE OF THE DEATH CERTIFICATE FORM

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
ROOM 165, 350 CAPITOL STREET, CHARLESTON, WV 25301

STATE FILE NUMBER

WRONG

John DOE

1 DECEDENT'S NAME (First, Middle, Last) | 2 SEX | 3 DATE OF DEATH (Month, Day, Year)

4 SOCIAL SECURITY NUMBER | 5a AGE-Last Birthday (Years) | 5b UNDER 1 YEAR Months Days | 5c UNDER 1 DAY Hours Minutes | 6 DATE OF BIRTH (Month, Day, Year) | 7 BIRTHPLACE (City and State or Foreign Country)

8 WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)

9a PLACE OF DEATH (Check only one; see instructions on other side): Inpatient | ER/Outpatient | DOA | Nursing Home | Residence | Other (Specify)

9b FACILITY NAME (If not institution, give street and number)

9c CITY, TOWN, OR LOCATION OF DEATH

9d COUNTY OF DEATH

10 MARITAL STATUS—Married, Never Married, Widowed, Divorced (Specify)

11 SURVIVING SPOUSE (If wife, give maiden name)

12a DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired)

12b KIND OF BUSINESS/INDUSTRY

13a RESIDENCE—STATE

13b COUNTY

13c CITY, TOWN, OR LOCATION

13d STREET AND NUMBER

13e INSIDE CITY LIMITS? (Yes or No)

13f ZIP CODE

14 WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Mexican, Puerto Rican, Cuban, Other Hispanic)

15 RACE—(American Indian, Asian, Black, White, etc.) (Specify)

16 DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0–12) | College (1–4 or 5+) | USA | FOR

17 FATHER'S NAME (First, Middle, Last)

18 MOTHER'S NAME (First, Middle, Maiden Surname)

19a INFORMANT'S NAME (Type/Print)

19b MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a METHOD OF DISPOSITION: Burial | Cremation | Removal from State | Donation | Other (Specify)

20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)

20c LOCATION—City or Town, State

21 SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH

22 NAME AND ADDRESS OF FACILITY

23a To the best of my knowledge, death occurred at the time, date, and place stated. Signature and Title ▶ DR. NO LICENSE.

23b DATE SIGNED (Month, Day, Year) 1/4/13

24 TIME OF DEATH 0900a

25 DATE PRONOUNCED DEAD (Month, Day, Year) 1/4/13

26 WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or No) NO

27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death): a. Undetermined Natural Causes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

28a WAS AN AUTOPSY PERFORMED? (Yes or No) NO

28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) NO

29 MANNER OF DEATH: Natural | Accident | Suicide | Homicide | Pending Investigation | Could not be Determined

30a DATE OF INJURY (Month, Day, Year)

30b TIME OF INJURY

30c INJURY AT WORK? (Yes or No)

30d DESCRIBE HOW INJURY OCCURRED

30e PLACE OF INJURY — At Home, Farm, Street, Factory, Office Building, etc. (Specify)

30f LOCATION (Street and Number or Rural Route Number, City or Town, State)

31a CERTIFIER (Check only one): CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed Item 23) — To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

PRONOUNCING AND CERTIFYING PHYSICIAN (Physician pronouncing death and certifying to cause of death) — To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

MEDICAL EXAMINER/CORONER — On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place and due to the cause(s) and manner as stated.

31b SIGNATURE AND TITLE OF CERTIFIER ▶ DR. License.

31c DATE SIGNED (Month, Day, Year) 1/4/13

32 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) DR. No License. 1 Medical Center Drive Morgantown, WV 26506

33 REGISTRAR'S SIGNATURE

34 DATE FILED (Month, Day, Year)

Completed by DR. NO License

DECEDENT | PARENTS | INFORMANT | DISPOSITION | PRONOUNCING PHYSICIAN ONLY (ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH) | CAUSE OF DEATH | CERTIFIER | REGISTRAR

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
ROOM 165, 350 CAPITOL STREET, CHARLESTON, WV 25301

STATE FILE NUMBER

CORRECT

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12b KIND OF BUSINESS/INDUSTRY

13a RESIDENCE—STATE

13b COUNTY

13c CITY, TOWN, OR LOCATION

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15 RACE—(American Indian, Asian, Black, White, etc.) (Specify)

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20b PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)

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22 NAME AND ADDRESS OF FACILITY

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27 PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

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DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

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28b WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or No) NO

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30b TIME OF INJURY

30c INJURY AT WORK? (Yes or No)

30d DESCRIBE HOW INJURY OCCURRED

30e PLACE OF INJURY — At Home, Farm, Street, Factory, Office Building, etc. (Specify)

30f LOCATION (Street and Number or Rural Route Number, City or Town, State)

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MEDICAL EXAMINER/CORONER — On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place and due to the cause(s) and manner as stated.

31b SIGNATURE AND TITLE OF CERTIFIER ▶ Dr License

31c DATE SIGNED (Month, Day, Year) 1/4/13

32 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) DR License 1 Medical Center Drive Morgantown, WV 26506

33 REGISTRAR'S SIGNATURE

34 DATE FILED (Month, Day, Year)

DECEDENT | PARENTS | INFORMANT | DISPOSITION | PRONOUNCING PHYSICIAN ONLY (ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH) | CAUSE OF DEATH | CERTIFIER | REGISTRAR

AUTOPSY CONSENT GENERAL INFORMATION

1. ANY PATIENT WHO PASSES AWAY AT RUBY IS ENTITLED TO AN AUTOPSY FREE OF CHARGE

2. AUTOPSY CONSENTS ARE AVAILABLE IN OPTIO

3. IF A FAMILY REQUESTS A BLACK LUNG AUTOPSY PLEASE REVIEW THE FOLLOWING:

   A. PLEASE ASK THE FAMILY IF THEY HAVE RECEIVED ANY BLACK LUNG BENEFITS IN THE PAST BEFORE AGREEING TO THE AUTOPSY. IF THE FAMILY HAS RECEIVED BENEFITS IN THE PAST AND THE AUTOPSY REPORT REVEALS THAT THERE IS NO BLACK LUNG/ PNEUMOCONIOSIS, THE FAMILY MIGHT BE REQUIRED TO PAY BACK ALL BENEFITS RECEIVED THUS FAR.

   B. IN ORDER TO PERFORM A BLACK LUNG AUTOPSY THE HEART AND LUNGS MUST BE EXAMINED.

   C. PLEASE ASSIST THE FAMILY WITH COMPLETING A NATIONAL COAL WORKER'S AUTOPSY CONSENT, RELEASE AND HISTORY FORM (2 PAGE FORM). THIS FORM MUST BE COMPLETED IN ADDITION TO THE WVUH AUTOPSY CONSENT FORM.

EXAMPLES OF THE AUTOPSY CONSENT FORM (AVAILABLE IN OPTIO) AND THE NATIONAL COAL WORKER'S AUTOPSY CONSENT, RELEASE, AND HISTORY FORM CAN BE FOUND ON THE FOLLOWING PAGES.

AUTOPSY REPORT GENERAL INFORMATION

HOSPITAL AUTOPSY REPORT (AUTOPSY REQUESTED BY FAMILY)

1. EXECUTOR OF ESTATE MUST REQUEST REPORT FROM MEDICAL RECORDS. MEDICAL RECORDS CAN BE REACHED AT 304-598-4109.

2. IT TAKES ON AVERAGE 30 TO 45 DAYS FOR AN AUTOPSY REPORT TO BE FINALIZED.

MEDICAL EXAMINER AUTOPSY REPORT (OFFICE OF THE CHIEF MEDICAL EXAMINERS TOOK JURISDICTION AND ORDERED AUTOPSY)

1. MEDICAL EXAMINER AUTOPSY REPORT MUST BE REQUESTED THROUGH THE CHIEF MEDICAL EXAMINERS OFFICE (OCME) IN CHARLESTON, WV. THE OCME CAN BE REACHED AT 304-558-6921, PRESS 0 WHEN THE AUTOMATED SYSTEM STARTS TO REACH AN INVESTIGATOR.

2. IT TAKES ON AVERAGE 6 TO 8 WEEKS FOR A MEDICAL EXAMINER AUTOPSY REPORT TO BE FINALIZED. THE FAMILY CAN STILL CONTACT THE OCME IN ADVANCE TO COMPLETE PAPERWORK FOR OBTAINING THE REPORT TO EXPIDIT THE PROCESS.

WVUHealthcare
WVU Hospitals and University Health Associates
Morgantown, WV 26506

AUTOPSY CONSENT
NS-034
CNSTS (R12/11)

DATE: _____/_____/_____

Autopsy Consent for (Name of deceased): _____

Date of Birth: _____/_____/_____ Date of Death: _____/_____/_____

I certify that I have the legal right to authorize an autopsy and/or dispose of the body of the decedent as next-of-kin according to West Virginia Statute. The complete autopsy report is part of the permanent medical record and must be obtained from the WVUH Medical Records Department. My relationship to the deceased is (PLEASE INITIAL ONLY ONE):

_____ 1) medical power of attorney representative

_____ 2) surviving spouse of the deceased
IF THERE IS NO MEDICAL POWER OF ATTORNEY REPRESENTATIVE (N.B COMMON LAW MARRIAGES ARE NOT RECONGIZED BY WEST VIRGINIA AND SPOUSE IS CONSIDERED NEXT OF KIN EVEN AFTER PROTRACTED LEGAL SEPARATION).

_____ 3) child of the deceased over the age of 18
IF THERE IS NO MEDICAL POWER OF ATTORNEY REPRESENTATIVE OR SURVIVING SPOUSE. HOWEVER THE CHILD'S PERMISSION SHALL NOT BE VALID IF ANY OTHER CHILD OF THE DECEASED OVER THE AFE OF 18 OBJECTS PRIOR TO SAID AUTOPSY AND OBJECTION SHALL BE MADE KNOWN IN WRITING TO THE PHYSICIAN WHO IS TO PERFORM THE AUTOPSY.

_____ 4) parent of the deceased
IF THERE IS NO MEDICAL POWER OF ATTORNEY NOR SURVIVING SPOUSE NOR ADULT CHILD OF THE DECEASED.

_____ 5) health care surrogate
IF THERE IS NO MEDICAL POWER OF ATTORNEY NOR SURVIVING SPOUSE NOR ADULT CHILD OF THE DECEASED AND ONE IS APPOINTED.

_____ 6) the duly appointed and acting fiduciary of the estate
IF THERE IS NO MEDICAL POWER OF ATTORNEY NOR SURVIVING SPOUSE NOR ADULT CHILD OF THE DECEASED NOR PATENT OF THE DECEASED NOR HEALTH CARE SURROGATE.

_____ 7) the person, firm, corporation or agency legally responsible for the financial obligation incurred in disposing the body of the deceased.
IF THERE IS NO MEDICAL POWER OF ATTORNEY NOR SURVIVING SPOUSE NOR ADULT CHILD OF THE DECEEASED NOR PARENT OF THE DECEASED NOR HEALTH CARER SURROGATE NOR DULY APPOINTED AND ACTING FIDUCIARY OF THE ESTATE.

IN THE EVENT THAT THE MEDICAL POWER OF ATTORNEY REPRESENTATIVE, THE SPOUSE, CHILD, PARENT OR HEALTH CARE SURROGATE OF THE DECEASED IS MENTALLY INCOMPENENT, THE PERSON AUTHORIZED TO CONSENT TO SUCH AUTOPSY SHALL BE THE NEXT IN THE ORDER OF PRIORITY AS ABOVE DEFINED, BROTHERS AND SISTERS OF THE DECEASED ARE NOT RECOGNIZED SPECIFICALLY IN THE WEST VIRGINIA STATUTE FOR LEGAL AUTHORIZATION OF AN AUTOPSY.

CONTINUED ON NEXT PAGE

Autopsy Consent for (Name of deceased): _____

In order to verify the cause of death and to aid in the diagnosis and treatment of other persons, I, the undersigned, request and permit the physician (s) authorized by the hospital to perform a (PLEASE INTIAL ONLY ONE):

_____ 1) Complete autopsy
_____ 2) Examination limited to (Please specify) _____
_____ 3) Restrictions (Please specify) _____

I authorize the presence of such other persons as the physician(s) and their discretion, permission to use the autopsy as an education resource. As to any tissue, body part, fluids or organs ("specimens") removed during or incidental to the autopsy, I authorize the physician(s) and/or WVUH to retain. Preserve and/or dispose for such tissues according to hospital policy for diagnosis, teaching, and/or research with the following exceptions: _____, as they may deem proper.

_____
Name

_____
Address

_____
Telephone

Signature: _____ Date/Time: _____
(Signature of person authorizing the autopsy)

WITNESSES

This was signed in my presence (or I have received faxed, telegraphic or verified telephonic or other verbal authorization) after complete disclosure and explanation of this document.

Verified telephone consent to AUTOPSY (check one) _____YES _____NO

_____ _____ _____
Signature of person and/or physician Obtaining consent | Pager # | Signature of Witness

_____ _____
Printed name of person obtaining consent | Printed name of Witness

Date: _____ Time: _____

Instructions: To be valid, this document 1) must be dated, 2) must be signed by the person authorizing autopsy, 3) must be signed by the person and/or physician obtaining permission, AND 4) signed by witness.

Form Approved
OMB No. 0920-0021
Exp. 03/31/2003

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health
National Coal Workers – Autopsy Study

Consent, Release and History Form
Federal Coal Mine Health and Safety Act of 1969

I, _____, _____ of
Name *Relationship*
_____, do hereby authorize the performance of an
Name of deceased miner
autopsy (_____) on said deceased. I understand that the report
Limitation, if any, on autopsy
and certain tissues as necessary will be released to the United States Public Health Service and to _____. I understand that any claims in regard
Name of physician securing autopsy
to the deceased for which I may sign a general release of medical information will result in the release of the information from the Public Health Service. I further understand that I shall not make any payment for the autopsy.

OCCUPATIONAL AND MEDICAL HISTORY

1. Date of Birth of Deceased _____
Month Day Year
2. Social Security Number of Deceased _____
3. Date and Place of Death _____
Month, Day, Year City, County, State
4. Place of Last Mining Employment:
   Name of Mine _____
   Name of Mining Company _____
   Mine Address _____
5. Date of Last Work or Retirement _____
6. Last Job Title at Mine of Last Employment _____
   (specify surface or underground) *e.g., Continuous Miner Operator, Motorman, Foreman, etc.*
7. Job Title of Principal Mining Occupation (that job to which miner devoted the most number of years): (specify surface or underground) _____
e.g., same as above
8. Smoking History of Miner:
   (a) Did he ever smoke cigarettes? Yes 9 No 9
   (b) If yes, for how many years? _____Years
   (c) If yes, how many cigarettes per day did he smoke on the average? _____ Number of cigarettes per day
   (d) Did he smoke cigarettes up until the time of his death? Yes 9 No 9
   (e) If no to (d), for how long before he died had he not been smoking cigarettes? _____

9. Total Years in Surface Employment in Coal Mining, by State (if known)

_____ _____
(Years) *(State)*

10. Total Years in Underground Coal Mining Employment, by State (if known)

_____ _____
(Years) *(State)*

_____
Signature

_____
Street

_____
City State Zip

_____
Telephone

Interviewer:

_____
Date

_____

CDC/NIOSH 2.6 (11-74)
(Formerly OSH-1 [2-71])

GENERAL INFORMATION REGARDING WVU HUMAN GIFT REGISTRY

1. ONCE A DONOR PASSES AWAY, HUMAN GIFT REGISTRY MUST RECEIVE A DEATH NOTIFICATION CALL FROM FAMILY OR NURSING STAFF TO 304-293-6322 (THIS # IS ANSWERED 24HRS A DAY).

2. A CALL SHEET WILL BE COMPLETED BY HUMAN GIFT REGISTRY TO DETERMINE IF THE DONOR STILL MEETS REQUIREMENTS FOR DONATION.

3. IF ACCEPTED BY HUMAN GIFT REGISTRY, A COMPLETED DEATH CERTIFICATE MUST BE SENT WITH THE DONOR.

4. IF REJECTED MY HUMAN GIFT REGISTRY, THE FAMILY WILL NEED TO SELECT A FUNERAL HOME.

5. FOLLOW NORMAL PROCEDURES FOR NOTIFYING MORGUE PERSONNEL WHEN READY FOR REMOVAL. PLEASE NOTIFY THEM IF THE DONOR IS FOR HUMAN GIFT REGISTRY OR FOR RELEASE TO FUNERAL HOME.

PLEASE SEE CALL SHEET ON THE FOLLOWING PAGE FOR THE SERIES OF QUESTIONS THAT WILL BE ASKED BY HUMAN GIFT REGISTRY.

Call Sheet		
Name of Donor:		
SSN #	DOB:	
Name & Phone # of Person Calling:		
Family Contact Name/Address/Phone #:		
Current Location of Body (include Phone #):		
Location at time of death:		
Cause of Death:		
Time & Date of Death:		
Person Taking Call:	Time & Date:	
MRS Notified ------- Time:	Date:	
A. All answers in this section should be marked "YES" before sending carrier.		
1. Is the deceased a donor?	**YES**	NO
2. Has the death certificate been signed by a certifying physician stating cause of death? Is the death certificate with the body?	**YES**	NO
3. Are cold storage facilities available if the body needs to be stored until morning?	**YES**	NO
4. Is the body located in West Virginia or within a 150 air mile radius of WVU?	**YES**	NO
B. All answers in this section should be "NO" in order to accept a donation.		
1. Unattended Death?	YES	**NO**
2. Has or will an autopsy be performed?	YES	**NO**
3. Has the body sustained major trauma? **	YES	**NO**
4. Is the body obese? Approx Weight:_____	YES	**NO**
5. Are there any amputations? If yes, what extremities?	YES	**NO**
6. Have there been any recent surgeries? (5-6 weeks)	YES	**NO**
7. To your knowledge does the family have any objection to this donation?	YES	**NO**
8. Does the donor have any known contagious diseases? ****	YES	**NO**
9. Has the donor been treated with therapertic radionuclides (anything other than Chemotherapy or External Beam Radiation). If yes, was the treatment within the past 4 weeks? {When was the last treatment?}	YES	**NO**
**** Drowning, Battery, Internal Injuries Due to Accidents, Gun Wounds, Burned, Etc.**		
***** AIDS, Hepatitis, TB, Herpes, Blood Bourne Infections**		

GENERAL INFORMATION REGARDING RELEASE OF DECEDENT TO FAMILY

1. IN THE STATE OF WV, FAMILY CAN TRANSPORT AND BURY THEIR LOVED ONE ON PRIVATE LAND.

2. PLEASE CONTACT MORGUE PERSONNEL TO COMPLETE RELEASE PROCESS SO THAT PROPER PROTOCOLS ARE FOLLOWED.

3. WVUH CONSENT AND RELEASE FORM (FORM 134.5) MUST BE COMPLETED BY FAMILY WITH A WITNESS PRESENT.

4. PLEASE EXPLAIN TO THE FAMILY THAT THE CONSENT AND RELEASE FORM STATES THAT THEY CAN TRANSPORT AND BURY THEIR LOVED ONE WITHIN THE GEOGRAPHICAL BOUNDS OF WV.

5. PLEASE EXPLAIN TO THE FAMILY THAT IT IS THEIR RESPONSIBILITY TO TRANSPORT AND DISPOSE OF THE REMAINS IN A MANNER WHICH COMPLIES WITH THE LAWS AND REGULATIONS OF THE STATE OF WV. IT IS ALSO THEIR RESPONSIBILITY TO ENSURE THAT THE DEATH CERTIFICATE INCLUDING THE BURIAL TRANSIT PERMIT IS FILED WITH THE WV DEPARTMENT OF HEALTH, DIVISION OF VITAL STATISTICS AS STATED ON THE CONSENT AND RELEASE FORM. **PLEASE SEE TAB E FOR NECESSARY PAPERWORK FOR INFANT DEATHS THAT MUST BE FILED WITH VITAL REGISTRATION.**

6. IF THE FAMILY HAS ANY QUESTIONS REGARDING WHAT NEEDS TO BE COMPLETED BY THE FAMILY ON THE EXPIRATION PAPERWORK AND HOW TO FILE THE DEATH CERTIFICATE AND BURIAL TRANSIT PERMIT (WHICH IS PART OF THE DEATH CERTIFICATE) WITH VITAL STATISTICS THEY CAN CONTACT ONE OF THEIR LOCAL FUNERAL HOMES FOR ASSISTANCE OR CALL WV VITAL REGISTRATION AT 304-558-2931.

PLEASE SEE THE FOLLOWING PAGE FOR A COPY OF THE WVUH CONSENT AND RELEASE FORM (FORM 134.5) TO BE USED WHEN RELEASING A DECEDENT TO FAMILY

WVUHealthcare
WVU Hospitals and University Health Associates
Morgantown, WV 26506
FORM 134.5 (R 11/13)

CONSENT AND RELEASE

I _____,
(Person assuming custody of the body)

_____ of _____,
(Relationship to deceased) (Deceased)

hereby request and authorize the release of his/her remains or fetal remains and/or placenta to my custody for transport and burial at a location of my choosing within the geographic bounds of the State of West Virginia.

I recognize and accept the risks of assuming responsibility for such transport and burial, including but not limited to potential psychological impact to myself and others.

I hereby release West Virginia University Hospitals from any and all liability for injury of any type or nature which may arise out of my removal of this body from the hospital and agree to indemnify WVUH for any liability which may so arise.

CHECK ONE BOX

☐ I am aware that no post-mortem (autopsy) examination has been performed on the deceased and do not desire that one be performed

☐ I am aware that a post-mortem (autopsy) examination has been performed on the decreased and that such an examination involves surgical incision, drains and exposing of internal bodily structures and organs.

I recognize that it is my responsibility to transport and dispose of these remains in a manner which complies with laws of this state and to forward a Burial and Transit Permit Form (blue copy of Death Certificate) to the West Virginia Department of Health Division of Vital Statistics immediately after burial of the deceased.

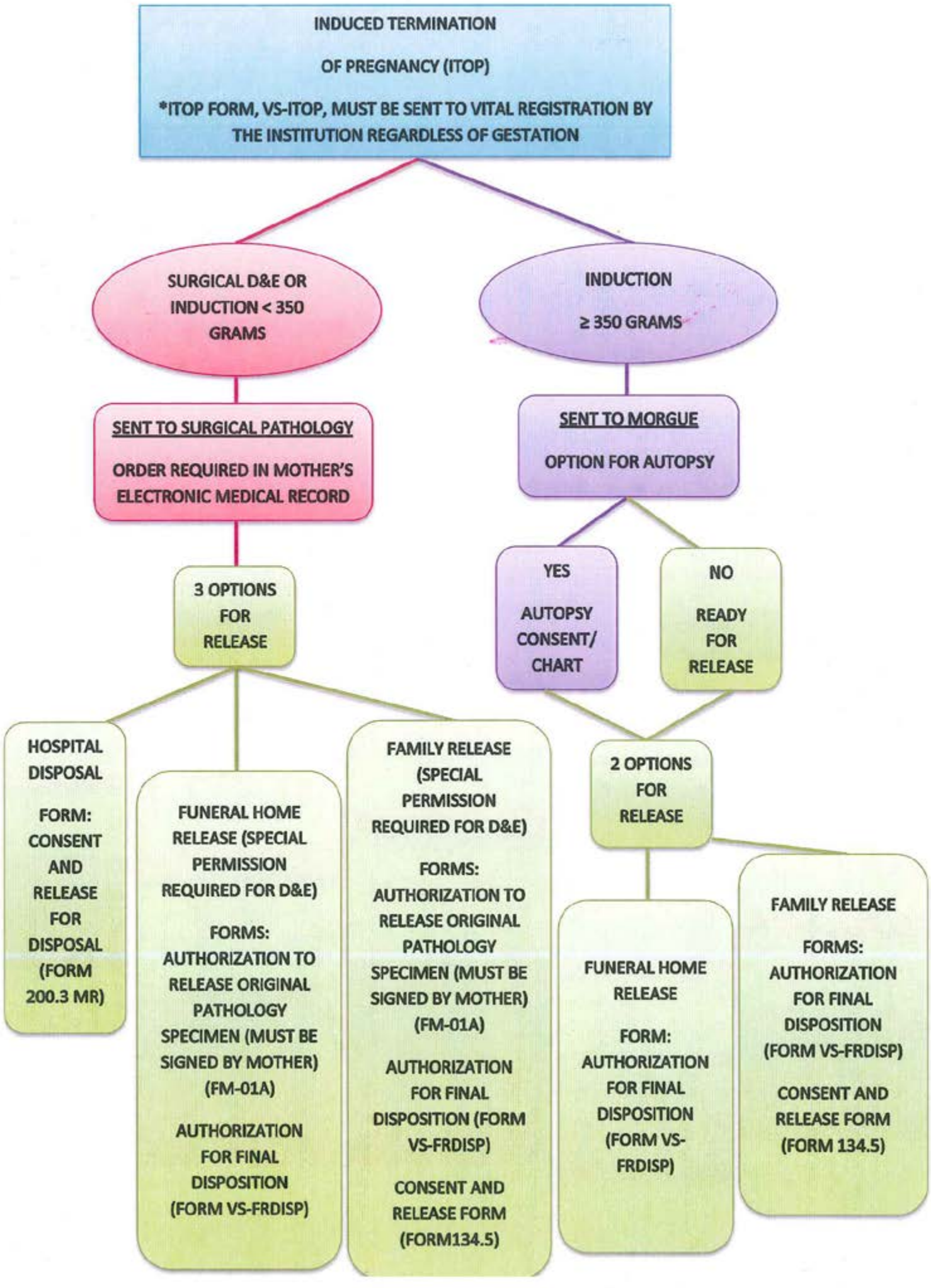
_____
Signature/Date/Time

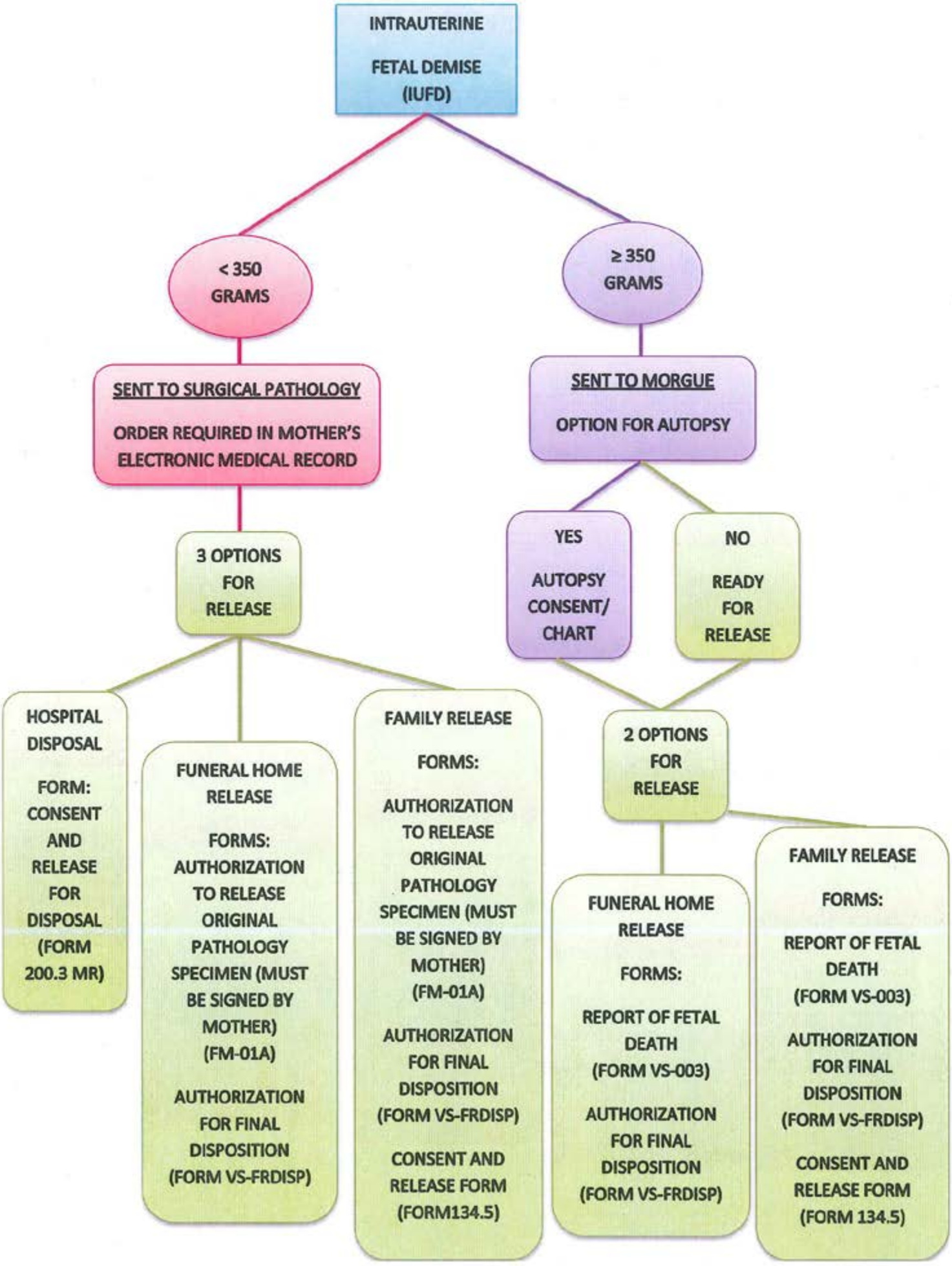
Copy to: Morgue file
Custodian of remains

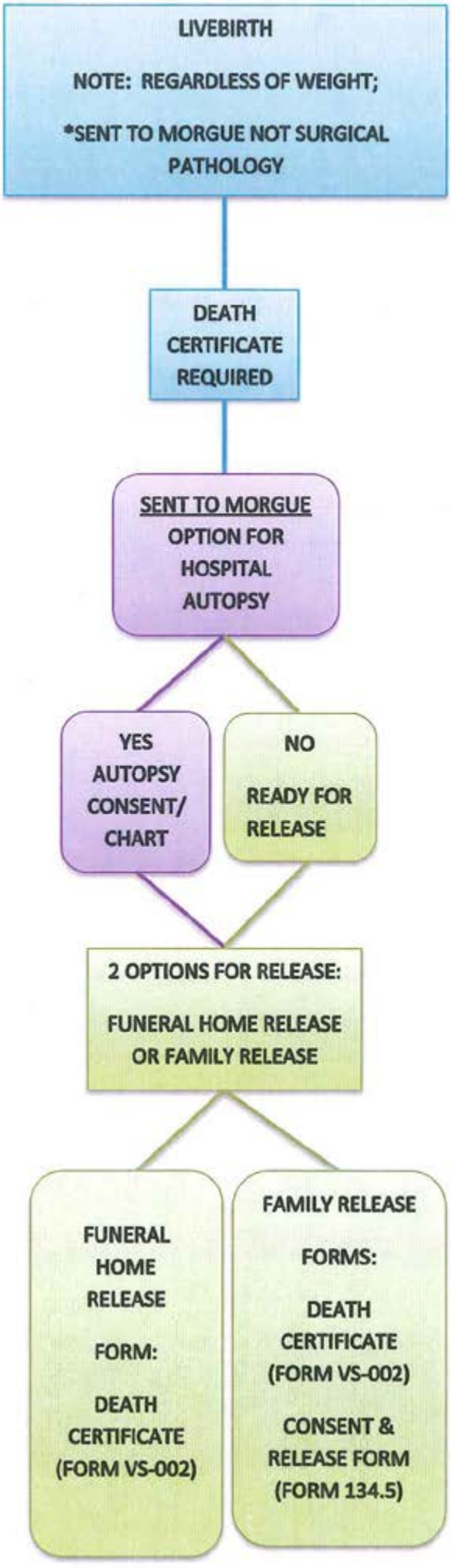
_____
Witness

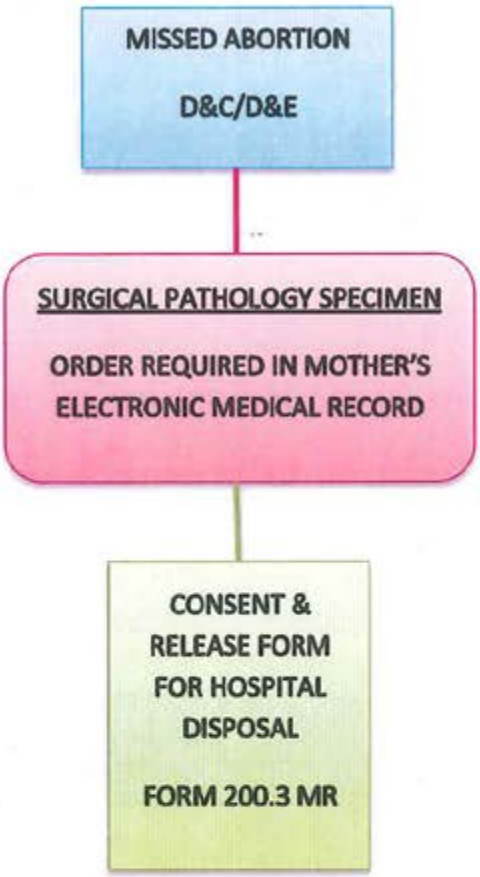
INFANT DEATHS GENERAL INFORMATION

1. Flowsheets
2. Examples of various forms listed on flowsheets


INDUCED TERMINATION
OF PREGNANCY (ITOP)
*ITOP FORM, VS-ITOP, MUST BE SENT TO VITAL REGISTRATION BY THE INSTITUTION REGARDLESS OF GESTATION
SURGICAL D&E OR INDUCTION < 350 GRAMS
INDUCTION ≥ 350 GRAMS
SENT TO SURGICAL PATHOLOGY
ORDER REQUIRED IN MOTHER'S ELECTRONIC MEDICAL RECORD
SENT TO MORGUE
OPTION FOR AUTOPSY
3 OPTIONS FOR RELEASE
YES
AUTOPSY CONSENT/ CHART
NO
READY FOR RELEASE
HOSPITAL DISPOSAL
FORM: CONSENT AND RELEASE FOR DISPOSAL (FORM 200.3 MR)
FUNERAL HOME RELEASE (SPECIAL PERMISSION REQUIRED FOR D&E)
FORMS: AUTHORIZATION TO RELEASE ORIGINAL PATHOLOGY SPECIMEN (MUST BE SIGNED BY MOTHER) (FM-01A)
AUTHORIZATION FOR FINAL DISPOSITION (FORM VS-FRDISP)
FAMILY RELEASE (SPECIAL PERMISSION REQUIRED FOR D&E)
FORMS: AUTHORIZATION TO RELEASE ORIGINAL PATHOLOGY SPECIMEN (MUST BE SIGNED BY MOTHER) (FM-01A)
AUTHORIZATION FOR FINAL DISPOSITION (FORM VS-FRDISP)
CONSENT AND RELEASE FORM (FORM134.5)
2 OPTIONS FOR RELEASE
FUNERAL HOME RELEASE
FORM: AUTHORIZATION FOR FINAL DISPOSITION (FORM VS-FRDISP)
FAMILY RELEASE
FORMS: AUTHORIZATION FOR FINAL DISPOSITION (FORM VS-FRDISP)
CONSENT AND RELEASE FORM (FORM 134.5)


INTRAUTERINE
FETAL DEMISE
(IUFD)
< 350
GRAMS
≥ 350
GRAMS
SENT TO SURGICAL PATHOLOGY
ORDER REQUIRED IN MOTHER'S
ELECTRONIC MEDICAL RECORD
SENT TO MORGUE
OPTION FOR AUTOPSY
3 OPTIONS
FOR
RELEASE
YES
AUTOPSY
CONSENT/
CHART
NO
READY
FOR
RELEASE
HOSPITAL
DISPOSAL
FORM:
CONSENT
AND
RELEASE
FOR
DISPOSAL
(FORM
200.3 MR)
FUNERAL HOME
RELEASE
FORMS:
AUTHORIZATION
TO RELEASE
ORIGINAL
PATHOLOGY
SPECIMEN (MUST
BE SIGNED BY
MOTHER)
(FM-01A)
AUTHORIZATION
FOR FINAL
DISPOSITION
(FORM VS-FRDISP)
FAMILY RELEASE
FORMS:
AUTHORIZATION
TO RELEASE
ORIGINAL
PATHOLOGY
SPECIMEN (MUST
BE SIGNED BY
MOTHER)
(FM-01A)
AUTHORIZATION
FOR FINAL
DISPOSITION
(FORM VS-FRDISP)
CONSENT AND
RELEASE FORM
(FORM134.5)
2 OPTIONS
FOR
RELEASE
FUNERAL HOME
RELEASE
FORMS:
REPORT OF FETAL
DEATH
(FORM VS-003)
AUTHORIZATION
FOR FINAL
DISPOSITION
(FORM VS-FRDISP)
FAMILY RELEASE
FORMS:
REPORT OF FETAL
DEATH
(FORM VS-003)
AUTHORIZATION
FOR FINAL
DISPOSITION
(FORM VS-FRDISP)
CONSENT AND
RELEASE FORM
(FORM 134.5)


LIVEBIRTH
NOTE: REGARDLESS OF WEIGHT;
*SENT TO MORGUE NOT SURGICAL PATHOLOGY
DEATH CERTIFICATE REQUIRED
SENT TO MORGUE OPTION FOR HOSPITAL AUTOPSY
YES AUTOPSY CONSENT/ CHART
NO
READY FOR RELEASE
2 OPTIONS FOR RELEASE:
FUNERAL HOME RELEASE OR FAMILY RELEASE
FUNERAL HOME RELEASE
FORM:
DEATH CERTIFICATE (FORM VS-002)
FAMILY RELEASE
FORMS:
DEATH CERTIFICATE (FORM VS-002)
CONSENT & RELEASE FORM (FORM 134.5)


MISSED ABORTION
D&C/D&E
SURGICAL PATHOLOGY SPECIMEN
ORDER REQUIRED IN MOTHER'S ELECTRONIC MEDICAL RECORD
CONSENT & RELEASE FORM FOR HOSPITAL DISPOSAL
FORM 200.3 MR

WVUHealthcare
WVU Hospitals and University Health Associates
Morgantown, WV 26506
FORM 134.5 (R 11/13)

CONSENT AND RELEASE

I _____,
(Person assuming custody of the body)

_____ of _____,
(Relationship to deceased) (Deceased)

hereby request and authorize the release of his/her remains or fetal remains and/or placenta to my custody for transport and burial at a location of my choosing within the geographic bounds of the State of West Virginia.

I recognize and accept the risks of assuming responsibility for such transport and burial, including but not limited to potential psychological impact to myself and others.

I hereby release West Virginia University Hospitals from any and all liability for injury of any type or nature which may arise out of my removal of this body from the hospital and agree to indemnify WVUH for any liability which may so arise.

CHECK ONE BOX

☐ I am aware that no post-mortem (autopsy) examination has been performed on the deceased and do not desire that one be performed

☐ I am aware that a post-mortem (autopsy) examination has been performed on the decreased and that such an examination involves surgical incision, drains and exposing of internal bodily structures and organs.

I recognize that it is my responsibility to transport and dispose of these remains in a manner which complies with laws of this state and to forward a Burial and Transit Permit Form (blue copy of Death Certificate) to the West Virginia Department of Health Division of Vital Statistics immediately after burial of the deceased.

_____
Signature/Date/Time

Copy to: Morgue file
Custodian of remains

_____
Witness

FORM VS-002

WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION
PHYSICIANS / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
ROOM 165, 350 CAPITOL STREET, CHARLESTON, WV 25301

TYPE/PRINT IN PERMANENT BLACK INK

STATE FILE NUMBER

NAME OF DECEDENT: For use by physician or institution

DECEDENT

1. DECEDENT'S NAME (First, Middle, Last) | 2. SEX | 3. DATE OF DEATH (Month, Day, Year)

4. SOCIAL SECURITY NUMBER | 5a. AGE-Last Birthday (Years) | 5b. UNDER 1 YEAR: Months / Days | 5c. UNDER 1 DAY: Hours / Minutes | 6. DATE OF BIRTH (Month, Day, Year) | 7. BIRTHPLACE (City and State or Foreign Country)

8. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or no)

9a. PLACE OF DEATH (Check only one; see instructions on other side)
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9b. FACILITY NAME (If not institution, give street and number) | 9c. CITY, TOWN, OR LOCATION OF DEATH | 9d. COUNTY OF DEATH

10. MARITAL STATUS–Married, Never Married, Widowed, Divorced (Specify) | 11. SURVIVING SPOUSE (If wife, give maiden name) | 12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) | 12b. KIND OF BUSINESS/INDUSTRY

13a. RESIDENCE–STATE | 13b. COUNTY | 13c. CITY, TOWN, OR LOCATION | 13d. STREET AND NUMBER

13e. INSIDE CITY LIMITS? (Yes or no) | 13f. ZIP CODE | 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes–If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes Specify | 15. RACE–American Indian, Black, White, etc (Specify) | 16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) 16A; College (1-4 or 5+) 16B

PARENTS

17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname)

INFORMANT

19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DISPOSITION

20a. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) | 20c. LOCATION–City or Town, State

21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶ | 22. NAME AND ADDRESS OF FACILITY

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-b only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated
Signature and Title ▶

23b. DATE SIGNED (Month, Day, Year)

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH M | 25. DATE PRONOUNCED DEAD (Month, Day, Year) | 26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? (Yes or no)

CAUSE OF DEATH

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no)

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)

29. MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be Determined

30a. DATE OF INJURY (Month, Day, Year) | 30b. TIME OF INJURY M | 30c. INJURY AT WORK? (Yes or No) | 30d. DESCRIBE HOW INJURY OCCURRED

30e. PLACE OF INJURY – At home, farm, street, factory, office building, etc (Specify) | 30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER

31a. CERTIFIER (Check only one)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 23)
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying to cause of death)
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated

31b. SIGNATURE AND TITLE OF CERTIFIER ▶ | 31c. DATE SIGNED (Month, Day, Year)

32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)

REGISTRAR

33. REGISTRAR'S SIGNATURE ▶ | 34. DATE FILED (Month, Day, Year)

FORM VS-002 (Rev. 7/2005)

STATE COPY

Form VS-003

REPORT OF FETAL DEATH

West Virginia Department of Health and Human Resources
Vital Registration Office

STATE FILE NUMBER

The Original Form IS A Legal Size Form

PARENTS

1. FACILITY NAME *(If not institution, give street and number)*
1a. NAME *(optional - at parent's request only)*
2. CITY, TOWN, OR LOCATION OF DELIVERY
3. COUNTY OF DELIVERY
4. DATE OF DELIVERY *(Month, Day, Year)*
5. SEX OF FETUS

TYPE / PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK.

6a. MOTHER'S NAME *(First, Middle, Last)*
6b. MAIDEN SURNAME
7. DATE OF BIRTH *(Month, Day, Year)*
8a. RESIDENCE - STATE
8b. COUNTY
8c. CITY, TOWN, OR LOCATION
8d. STREET AND NUMBER
8e. INSIDE CITY LIMITS? *(Yes or No)*
8f. ZIP CODE
9. FATHER'S NAME *(First, Middle, Last)*
10. DATE OF BIRTH *(Month, Day, Year)*

CAUSE

11. PART I. FETAL DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)
SPECIFY FETAL OR MATERNAL

Fetal or maternal condition directly causing fetal death. Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a) stating the underlying cause last

IMMEDIATE CAUSE: (a)
DUE TO, OR AS A CONSEQUENCE OF: (b)
DUE TO, OR AS A CONSEQUENCE OF: (c)

11. PART II. OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER contributing to fetal death but not related to cause given in Part I

12. FETUS DIED BEFORE LABOR ☐
DURING LABOR OR DELIVERY ☐
UNKNOWN ☐

13a. AUTOPSY YES ☐ NO ☐

13b. IF YES, WERE AUTOPSY FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH?

CERTIFIER

I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED ABOVE AND THE FETUS WAS BORN DEAD
14a. SIGNATURE X _____
DATE SIGNED *(month, day, year)* 14b.
14c. ATTENDANT TYPE - M.D., D.O., C.N.M., OTHER MIDWIFE, Other: *(Specify)*

CERTIFIER - MAILING ADDRESS *(Street or R.F.D. No., city or town, state, zip)* 14d.
AUTHORIZED OFFICIAL *(If delivery not attended by physician)* 15. SIGNATURE

BURIAL

BURIAL, CREMATION, OR REMOVAL *(Specify)* 16a.
CEMETERY OR CREMATORY - NAME 16b.
LOCATION *(City or town, state)* 16c.
DATE *(month, day, year)* 16d.
FUNERAL HOME - NAME AND ADDRESS *(Street or R.F.D. No., city or town, state, zip)* 17a
FUNERAL DIRECTOR - SIGNATURE 17b. X _____
REGISTRAR - SIGNATURE 18a.
DATE RECEIVED BY LOCAL REGISTRAR *(month, day, year)* 18b.

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	19. OF HISPANIC ORIGIN? *(Specify No or Yes - if yes specify Cuban, Mexican, Puerto Rican, etc.)*	20. RACE - American Indian, Black, White etc. *(Specify below)*	21. EDUCATION *(Specify only highest grade completed)* Elementary / Secondary (0-12)	21. EDUCATION College (1-4, OR 5 +)	22. OCCUPATION AND BUSINESS / INDUSTRY *(Worked during last year)* Occupation	22. OCCUPATION AND BUSINESS / INDUSTRY Business / Industry
MOTHER	19a. ☐No ☐Yes *Specify:*	20a.	21a.	21b.	22a.	22b.
FATHER	19b. ☐No ☐Yes *Specify:*	20b.	21c.	21d.	22c.	22d.

MEDICAL AND HEALTH INFO

23. PREGNANCY HISTORY *(Complete each section)*

LIVE BIRTHS
23a. Now Living — Number ____ ☐ None
23b. Now Dead — Number ____ ☐ None
23c. DATE OF LAST LIVE BIRTH *(Month, Year)*

OTHER TERMINATIONS *(Spontaneous and induced at any time after conception)*
23d. *(Do not include this fetus)* — Number ____ ☐ None
23e. DATE OF LAST OTHER TERMINATION *(Month, Year)*

24. MOTHER MARRIED? *(At delivery, conception, or any time between)* *(Yes or No)*
25. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*
26. MONTH OF PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. *(Specify)*
27. PRENATAL VISITS - Total Number *(If none, so state)*
28. WEIGHT OF FETUS *(Specify Units)*
29. CLINICAL ESTIMATE OF GESTATION *(Weeks)*
30a. PLURALITY - Single, Twin, Triplet, etc. *(Specify)*
30b. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. *(Specify)*

MULTIPLE BIRTHS
Enter State File Number for Mate(s)
LIVE BIRTH(S)

FETAL DEATH(S)

31a. MEDICAL RISK FACTORS FOR THIS PREGNANCY *(Check all that apply)*

- Anemia (Hct. < 30/Hgb. < 10) ..... 01 ☐
- Cardiac disease ..... 02 ☐
- Acute or chronic lung disease ..... 03 ☐
- Diabetes ..... 04 ☐
- Genital herpes ..... 05 ☐
- Hydramnios / Oligohydramnios ..... 06 ☐
- Hemoglobinopathy ..... 07 ☐
- Hypertension, chronic ..... 08 ☐
- Hypertension, pregnancy-associated ..... 09 ☐
- Eclampsia ..... 10 ☐
- Incompetent cervix ..... 11 ☐
- Previous infant 4000 + grams ..... 12 ☐
- Previous preterm or small-for-gestational-age infant ..... 13 ☐
- Renal disease ..... 14 ☐
- Rh sensitization ..... 15 ☐
- Uterine bleeding ..... 16 ☐
- None ..... 00 ☐
- Other _____ (Specify) ..... 17 ☐

32. OBSTETRIC PROCEDURES *(Check all that apply)*

- Amniocentesis ..... 01 ☐
- Electronic fetal monitoring ..... 02 ☐
- Induction of labor ..... 03 ☐
- Stimulation of labor ..... 04 ☐
- Tocolysis ..... 05 ☐
- Ultrasound ..... 06 ☐
- None ..... 00 ☐
- Other _____ (specify) ..... 07 ☐

33. COMPLICATIONS OF LABOR AND/OR DELIVERY *(Check all that apply)*

- Febrile (> 100°F, or 38°C) ..... 01 ☐
- Meconium, moderate / heavy ..... 02 ☐
- Premature rupture of membrane (> 12 hours) ..... 03 ☐
- Abruptio placenta ..... 04 ☐
- Placenta previa ..... 05 ☐
- Other excessive bleeding ..... 06 ☐
- Seizures during labor ..... 07 ☐

35. CONGENITAL ANOMALIES OF FETUS *(Check all that apply)*

- Anencephalus ..... 01 ☐
- Spina bifida / Meningocele ..... 02 ☐
- Hydrocephalus ..... 03 ☐
- Microcephalus ..... 04 ☐
- Other central nervous system anomalies *(Specify)* _____ ..... 05 ☐
- Heart malformations ..... 06 ☐
- Other circulatory / respiratory anomalies *(Specify)* _____ ..... 07 ☐
- Rectal atresia / stenosis ..... 08 ☐
- Tracheo-esophageal fistula / Esophageal atresia ..... 09 ☐
- Omphalocele / Gastroschisis ..... 10 ☐
- Other gastrointestinal anomalies *(Specify)* _____ ..... 11 ☐
- Malformed genitalia ..... 12 ☐
- Renal agenesis ..... 13 ☐
- Other urogenital anomalies *(Specify)* _____ ..... 14 ☐

Form VS-ITOP

WEST VIRGINIA Department of Health & Human Resources

Health Statistics Center
Bureau for Public Health

REPORT OF INDUCED TERMINATION OF PREGNANCY (ITOP)

STATE FILE NUMBER

1. FACILITY NAME (If not clinic or hospital, give address also)	2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION	3. COUNTY OF PREGNANCY TERMINATION

4. PATIENT'S ID	5. AGE	6. MARITAL STATUS	7. DATE OF PREGNANCY TERMINATION
		☐ MARRIED ☐ NEVER MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED	month / day / year

8a. RESIDENCE-STATE	8b. COUNTY

9. OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)	10. RACE (MARK ALL APPLICABLE)	11. EDUCATION (Circle *only highest grade completed*)
☐ NO ☐ YES If YES, Specify:	☐ American Indian ☐ Black ☐ White ☐ Other (Specify) _____	0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 16+ 11a. Currently in School? ☐ NO ☐ YES

12. DATE LAST NORMAL MENSES BEGAN	13. CLINICAL ESTIMATE OF GESTATION (COMPLETED WHOLE Weeks -NO PARTIAL WEEKS)	14. PREVIOUS PREGNANCIES (Complete each section)			
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now Living	14b. Now Dead	14c. Spontaneous (stillbirth/miscarriage)	14d. Induced (Do not include this termination)
month / day / year		Number _____ ☐ None	Number _____ ☐ None	Number _____ ☐ None	Number _____ ☐ None

15. TYPE OF TERMINATION PROCEDURES

	15a. PRIMARY PROCEDURE THAT TERMINATED THE PREGNANCY (check only one) A BOX IN THIS COLUMN MUST BE TICKED	15b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY (check all that apply) IF NONE, TICK NONE (0) AT BOTTOM
1	☐ Suction Curettage	☐ 1
2	☐ _____ Medical (Nonsurgical), Specify Medication(s) _____	☐ 2
3	☐ Dilation and Evacuation (D&E)	☐ 3
4	☐ Intra-Uterine Instillation of Saline	☐ 4
5	☐ Intra-Uterine Instillation of Prostaglandin	☐ 5
6	☐ Sharp Curettage (D&C)	☐ 6
7	☐ Hysterectomy	☐ 7
8	☐ Hysterotomy	☐ 8
9	☐ _____ Other (Specify) _____	☐ 9
		None ☐ 0

15c. WAS THIS PROCEDURE PERFORMED BECAUSE OF A KNOWN FETAL GENETIC DEFECT? ☐ UNK ☐ NO ☐ YES If yes, specify _____

15d. WAS THIS AN EMERGENCY PROCEDURE PERFORMED BECAUSE OF AN IMMEDIATE THREAT OR GRAVE RISK TO THE HEALTH OF THE PATIENT? ☐ NO ☐ YES

15e. SOURCE OF PAYMENT FOR PROCEDURE (MARK ALL THAT ARE APPLICABLE) ☐ SELF PAY ☐ PRIVATE INS ☐ MEDICAID ☐ OTHER (specify) _____

16. COUNSELING AND INFORMATIONAL GUIDANCE AS REQUIRED BY WV STATE CODE §16-2I-1 et seq. FOR ALL NON-EMERGENCY PROCEDURES WAS PROVIDED. ☐ NO ☐ YES

17. NAME OF ATTENDING PHYSICIAN (Type/Print)	18. NAME OF PERSON COMPLETING THE REPORT (Type/Print)

IF THE PATIENT IS LESS THAN 18 YEARS OF AGE, SEE BACK OF THIS FORM FOR COMPLETION

Completed forms are due no later than the 10th of the month following the month the procedure was performed.

Mail to:
ATTN: Registrar's Office - ITOP
Vital Registration
PO Box 11012
Charleston, WV 25339-1012

VS-ITOP-12/2007

Induced Termination of Pregnancy (ITOP) means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and which does not result in a live birth. This definition excludes management of prolonged retention of products of conception following fetal death.

West Virginia Department of Health & Human Resources

West Virginia Bureau for Public Health

AUTHORIZATION FOR FINAL DISPOSITION

Form VS-FRDISP

Fetal Death

(This form replaces and is to be used in lieu of the former burial / transit permit for fetal deaths.)

PARENT:

I hereby authorize _____ to complete final disposition of the
(funeral director, institution, or other applicable person or legal entity)

fetus born on _____ at _____ _____.
(date of delivery - month, day, year) (name of institution or facility or address, as is applicable)

(PRINT name of parent/ME) _____ _____ _____/_____
(signature of parent/ Medical Examiner) (date)

PLACE OF DISPOSITION:

I, _____, certify the fetal remains were interred or otherwise disposed of on _____ at
(name of person who will sign below -PRINT) (date of disposition)

_____. _____ _____/_____
(place of disposition) (signature - sexton, person in charge of place of interment or disposition) (date)

PHYSICIAN OR INSTITUTION RELEASING REMAINS: This fetal death ☐ was ☐ was not reportable as a Report of Fetal Death per WV State Code §16-5-21. A reportable fetal death must be reported within 5 days of delivery.

IT IS THE RESPONSIBILITY OF THE SEXTON OR OTHER PERSON IN CHARGE OF THE PLACE OF INTERMENT OR DISPOSITION TO RETURN THIS COMPLETED AUTHORIZATION TO THE FUNERAL DIRECTOR, INSTITUTION, OR OTHER APPLICABLE PERSON OR LEGAL ENTITY TO WHOM THE FETAL REMAINS WERE RELEASED.

IT IS THE RESPONSIBILITY OF THE FUNERAL DIRECTOR, INSTITUTION, OR OTHER APPLICABLE PERSON OR LEGAL ENTITY TO WHOM FETAL REMAINS WERE RELEASED TO RETURN THIS COMPLETED AUTHORIZATION TO THE VITAL REGISTRATION OFFICE BY THE 10TH DAY OF THE MONTH AFTER RECEIPT. MAIL ALL FORMS TO:

ATTN: Registration Unit - FD, Vital Registration Office, PO Box 11012, Charleston, WV 25339-1012

VS-FRDISP-Rev.04/2008

The original Form is a half sheet Form.

Form FM-01A

WVUHealthcare
Morgantown, WV 26506
(FM-01A) (11/12)

AUTHORIZATION TO RELEASE ORIGINAL PATHOLOGY LABORATORY SPECIMEN

I, _____(patient's name), D.O.B. _____, hereby request and authorize West Virginia University Hospitals, Inc. to release the original pathology laboratory specimen, identified with Accession No. _____, and further identified as a

"_____" to:

Name:_____

Address: _____

_____

_____

I understand and acknowledge that by requesting that West Virginia University Hospitals, Inc. relinquish control of the original pathology laboratory specimen described above, West Virginia University Hospitals, Inc. will no longer have the specimen or any part or copies thereof in its possession. In consideration of West Virginia University Hospitals, Inc. releasing said original pathology laboratory specimen at my request, I expressly agree to indemnify and hold harmless West Virginia University Hospitals, Inc., its affiliates, subsidiaries, assigns, agents, servants, employees, attorneys and insurers, from any and against all future claims, losses, damages or causes of action that may arise, as a result of West Virginia University Hospitals, Inc. no longer having in its possession the original pathology laboratory specimen described above. I hereby release and hold harmless West Virginia University Hospitals, Inc. from any liability, whether civil, criminal or administrative, related to spoliation of evidence or failure to maintain my medical records or other medical information related to the original pathology laboratory specimen described above.

Signed:

_____ _____

Patient's Name Date Time

_____ _____

Witness Date Time

Form 200.3 MR

WEST VIRGINIA UNIVERSITY HOSPITALS
Morgantown, West Virginia

Consent and Release for Disposal

(Addressograph)

Date: _____ / _____ / _____

I, _____, _____,
(Legal Next of Kin) (Relationship to Deceased)

hereby request and authorize the release of pregnancy remains to West Virginia University Hospitals Inc. (WVUH) for disposition in accordance with hospital policy.

I accept the risks of WVUH assuming responsibility for transportation and/or disposition of the remains, including but not limited to potential psychological impact to myself and others. I hereby forever release, acquit and discharge WVUH, its insurers, subsidiaries, affiliates, successors and assigns, its officers, directors, agents, servants and employees of and from all liability, claims, actions, causes of action, damages or demands, of every kind and character, loss of income and all expenses heretofore or hereafter incurred, in any manner now or hereafter arising directly or indirectly from the disposition of these remains and agree to indemnify WVUH for any liability which may so arise.

I recognize that it is WVUH's responsibility to transport and dispose of these remains in a manner, which complies, with the laws of this state and to forward an appropriate documentation to the West Virginia Department of Health, Division of Vital Statistics immediately after disposal of pregnancy remains prior to viability.

_____ _____ _____ / _____ / _____
Signature Title Date

_____ _____ _____ / _____ / _____
Witness Signature Title Date