



International Skeletal Dysplasia Registry

Mother's Identification:

Estimated Gestational Age of Fetus: _____ Weeks

AUTHORIZATION FOR FETAL EXAMINATION INCLUDING DISSECTION

I, _____, bearing the relationship of parent to
Parent's Name (Please Print)

Baby Boy / Girl _____, and entitled by law to control the fetal remains, hereby authorize and request that authorized personnel in the International Skeletal Dysplasia Registry ("ISDR") and Laboratory of Cedars-Sinai Medical Center and their staff to perform a post-mortem examination, including dissection and removal of bone and tissue samples from the remains of said fetus. The examination and dissection will also be done in preparation for the work to be done as contemplated in my separate consent to have information relating to the fetus included in ISDR research. I also authorize ISDR Laboratory personnel to remove such specimens, tissues and/or organs and to retain, preserve and/or contribute the same for such other scientific purposes as they shall deem proper, and that they may be disposed of by the Medical Center in accordance with applicable Medical Center policies. Other than for such items, the fetus will be treated as provided at the bottom of the form. I understand that any such information gained from the examination will be held confidential to the extent allowed by law.

This authorization shall be subject to the following restrictions: _____

Signature of Parent

Date

Name of Witness (Please Print)

Signature of Witness

Date

Time

Return of Fetus: Mortuary Authorization (Completed by Next of Kin)

I, _____, bearing relationship of _____
to _____, hereby authorize the representative of _____
Mortuary to remove the body of said deceased from Cedars-Sinai
Medical Center.

Signature of Parent

Date

Name of Witness (Please Print)

Signature of Witness

Date

Time

Disposition of Remains

I hereby relinquish responsibility for the disposition of fetal remains to Cedars-Sinai Medical Center if gestational age is less than 20 weeks.

Signature of Parent

Date

Name of Witness (Please Print)

Signature of Witness

Date

Time

This form MUST accompany the fetal remains.