THE AUTOPSY Doctor™

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Authorization for Private Autopsy Examination

Autopsy service is paid up front including an *estimated* transport fee as a reimbursement. Special studies such as toxicology, radiology, neuropathology, excessive record review more than 2 hours; will be separately billed. Verbal preliminary call (30 min) *usually* within 1 day. No further updates until report complete. Final report *timeline varies* (depends on complexity) and emailed. Includes 1 hour total discussions. Final Diagnosis Inc. HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law. See "Procedures" for full statement.

Info of Decedent: Male / Female Ht: ____ Wt: ____ = BMI ___ (35 is $250, 40 is $500, 45 is 750, each 5 is +$250)
Name: Age: Race:

Date of birth: Date of death: Location: Home / Hospital

Funeral Home Name: Contact Person:
Address: Phone:

Recent Hospitalization? Name: Phone:
Address: Dates:

***May also speak to:** Relation: Phone:

Smoking ever? Y / N **Alcohol/drug abuse** ever? Y / N Explain: _____

Medical History: _____
_____
_____

***Terminal event** or how were they found:_____
Specific concerns: _____
_____
Medications: _____
*Toxicology concerns: Y / N What?_____ Autopsy restrictions:_____
Blood and fluids retained for tox are held for 2 years. Contact us prior to expiration and pay $50/year to hold longer.
Has a Medical Examiner/Coroner been notified? Y / N / Don't know County:_____
Were they an **Organ** / **Tissue** / **Eye donor** (circle)? What agencies? _____
Already embalmed? **Y / N / Will be** Viewing after autopsy? **Y / N** Burial or cremation? _____
Can we retain the **BRAIN** if the pathologist determines it is necessary? Circle **Y / N & Initial**: _____

SIGNATURES *AND* FINANCIAL RESPONSIBILITY (*Include payee if different than authorizer)*
Next of Kin Printed Name: _____ Payee:_____
Sign and date: _____ ____/____/____ Payee: X _____
(**Circle One**: Executor of estate, health care surrogate, spouse, adult child, parent, sibling, _____)
Cell:_____Home:_____ Email:_____
Payee billing address:

*10% monthly late fees after 30 days on unpaid balances.