

**AUTOPSY AND PATHOLOGY SERVICES, P.A.**

**3007 WOODLAND HILLS DR. #123**

**KINGWOOD, TEXAS 77339-1403**

**www.autopsypros.com**

**24 HOURS: (713) 200-0173**

**OFFICE: (281) 359-1953**

**FAX: (281) 657-6834**

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**INSTRUCTIONS REGARDING PRIVATE AUTOPSIES**

Please fill out the enclosed forms as completely as possible.

- (1) Texas Department of State Health Services - Postmortem Examination or Autopsy Consent Form.
  - (A) Must be signed by the legal next-of-kin. **This needs to be returned BEFORE the pathologist will perform the autopsy.** It may be faxed but original must be mailed or brought to pathologist.
  - (B) Must be signed by a witness over the age of 18 years.
- (2) Supplemental Autopsy Consent Form and Release.

This form is necessary to allow release of the decedent to the funeral home selected by the family and addresses reports and other details regarding the autopsy.

  - (A) Must be signed by the legal next-of-kin. **This needs to be returned BEFORE the pathologist will perform the autopsy.** It may be faxed but original must be mailed or brought to pathologist.
  - (B) Must be signed by a witness over the age of 18 years.
- (3) Questionnaire Form A & B.

Please include as much information as possible. Use back of sheet if necessary. This background information is important for the pathologist to provide a more complete report.
- (4) Credit Card Form-for payment with Visa, MasterCard, Discover or American Express.

**A CREDIT CARD, CASHIER'S CHECK OR MONEY ORDER IS PREFERRED FOR PAYMENT.**

**PAYMENT MUST BE MADE PAYABLE TO: AUTOPSY AND PATHOLOGY SERVICES, P.A. FOR THE AMOUNT OF \$2,800.00 PLUS TRANSPORT FEE (IF ANY) AND TOXICOLOGY (IF APPLICABLE). FULL PAYMENT IS DUE PRIOR TO TRANSPORT AND AUTOPSY IS PERFORMED.**

All forms should be brought with the decedent. If they are faxed, please mail the originals to Autopsy and Pathology Services, P.A. as soon as possible. Transportation of the body is usually arranged by the funeral home handling the funeral services. This office can also arrange to have the decedent transported to our facility at a reasonable fee. **Please note that toxicology analysis cannot be done on a body that has already been embalmed.** If you have any additional questions, please do not hesitate to contact our office.

Thank you,

Jessie Adame, M.D.

Albert I. Chen, M.D.



# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

## POSTMORTEM EXAMINATION OR AUTOPSY CONSENT FORM

This form is prescribed under Article 49.34 of the Code of Criminal Procedure. Please see the reverse side for further information regarding the law and the completion of this form.

NAME OF DECEDENT:	DATE OF DEATH
NAME AND TITLE OF PHYSICIAN PERFORMING PROCEDURE: <b>JESSIE ADAME, MD (PATHOLOGIST) OR ALBERT I. CHEN, MD (PATHOLOGIST)</b>	TEXAS LICENSE NUMBER: <b>J. ADAME, MD -H9743 A.I. CHEN, MD-L8304</b>
NAME OF FACILITY AND DEPARTMENT WHERE THE PROCEDURE WILL BE PERFORMED: <b>AUTOPSY AND PATHOLOGY SERVICES, PA-MORGUE</b>	

The physician may be required to remove and retain organs, fluids, prosthetic devices, or tissue for purposes of comprehensive evaluation or accurate determination of a cause of death.

PERMISSION IS GRANTED FOR A COMPLETE UNRESTRICTED AUTOPSY UNLESS A RESTRICTION OR LIMITATION IS SELECTED BELOW:

\_\_\_\_ Exam is restricted to brain                      \_\_\_\_ Exam is restricted to the chest and abdomen only

\_\_\_\_ Exam is restricted to the chest cavity                      \_\_\_\_ Exam is restricted to the abdominal cavity

\_\_\_\_ Other: (Specify) \_\_\_\_\_

**IF NO RESTRICTION OR LIMITATION IS SELECTED, THEN PERMISSION IS GRANTED FOR A COMPLETE UNRESTRICTED AUTOPSY TO BE PERFORMED.**

I authorize the release of the remains to the funeral services provider or person listed below after examination.

Name of Funeral Service Provider or Person:	Telephone Number:
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\_\_\_\_\_  
Authorizing Person's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorizing Person's Printed Name

\_\_\_\_\_  
Relationship to Decedent

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Printed Name

If I am one of several individuals of the same relation (e.g. siblings) entitled to give consent to the postmortem examination or autopsy on the above named decedent, then, by my signature above, I declare that the decedent has no surviving spouse or legal guardian and no executor or administrator of the decedent's estate exists. I represent that all of my siblings have no objection to a postmortem examination or autopsy being performed on the above decedent.

**Warning: It is a felony to falsify information on a Vital Statistics application, record or report. The penalty for knowingly making a false statement on this form or for signing a form which contains a false statement is 2 to 10 years imprisonment and a fine of up to \$10,000. (Health and Safety Code §195.003)**



# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

## POSTMORTEM EXAMINATION OR AUTOPSY CONSENT FORM

This form **MUST** be completed by the person authorized to give consent to a postmortem examination or autopsy before such procedure can be conducted [CCP Art. 49.32].

This form IS NOT required if an autopsy is ordered by a Justice of the Peace or Medical Examiners as part of a death inquest or ordered by the Texas Department of Criminal Justice under Texas Government Code §501.055 [CCP Art. 49.31].

### ***Persons Authorized To Consent to Postmortem Examination or Autopsy***

Consent for a postmortem examination or autopsy may be given by any following persons, who are reasonably available, in the order of priority listed:

- the spouse of the decedent;
- the person acting as guardian of the person of the decedent at the time of death or the executor or administrator of the decedent's estate;
- the adult children of the decedent;
- the parents of the decedent; and
- the adult siblings of the decedent.

If there is more than one person of the same relation entitled to give consent to a postmortem examination or autopsy, consent may be given by a member of the same relationship unless another person of the same relationship files an objection with the physician, medical examiner, justice of the peace, or county judge. If an objection is filed, the consent may be given only by a majority of the persons of the same relationship of the class who are reasonably available. An example of this would be multiple surviving adult children.

A person may not give consent if, at the time of the decedent's death, a person granted higher priority as listed above is reasonably available to give consent or to file an objection to a postmortem examination or autopsy.

### ***Anatomical Gift by Decedent Prior To Death***

An anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education by

- the donor,
  - if the donor is an adult; or
  - if the donor is a minor and is:
    - emancipated; or
    - authorized under state law to apply for a driver's license because the donor is at least 16 years of age and:
      - circumstances allow the donation to be actualized prior to 18 years of age; and
      - an organ procurement organization obtains signed written consent from the minor's parent, guardian, or custodian;
- an agent of the donor, unless the medical power of attorney or other record prohibits the agent from making an anatomical gift; a parent of the donor, if the donor is an unemancipated minor; or
- the donor's guardian.

### ***Anatomical Gift of Decedent's Remains by Someone Other Than the Decedent***

Unless the decedent has refused to make an anatomical gift in writing prior to death, an anatomical gift of a decedent's body or part for the purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

- an agent of the decedent at the time of death who could have made an anatomical gift under Section 692A.004(2) immediately before the decedent's death;
- the spouse of the decedent;
- adult children of the decedent;
- parents of the decedent;
- adult siblings of the decedent;
- adult grandchildren of the decedent;
- grandparents of the decedent;
- an adult who exhibited special care and concern for the decedent;
- the persons who were acting as the guardians of the person of the decedent at the time of death;
- the hospital administrator; and
- any other person having the authority to dispose of the decedent's body.

If there is more than one member of a class listed above entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to may be receiving the anatomical gift and knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

A person may not make an anatomical gift if, at the time of the decedent's death, a person in a class higher than them is reasonably available to make or to object to the making of an anatomical gift.

### ***Death Inquest by Medical Examiners***

Some deaths may require a medical examiner to conduct an investigation or inquest and cause of death certification which may include an autopsy. [CCP Art. 49.25 §6]. These include:

- A body was found and the cause and circumstances of the death are unknown.
- The death is believed to be an unnatural death from a cause other than a legal execution (accident, suicide, or homicide).
- The death occurred in prison or in jail.
- The death occurred within 24 hours of admission to a Hospital
- The death occurred without medical attendance.
- The physician is unable to certify the cause of death.
- The deceased is under six (6) years of age.

### ***Nonaffiliated Physicians***

Before signing this form, a representative of the hospital or other institution where the death occurred is required to inform a person authorized to consent to a postmortem examination or autopsy that they may request that a physician who is not affiliated with the hospital or other institution where the death occurred to perform the postmortem examination or autopsy at another hospital or institution.

A person authorized to consent to a postmortem examination or autopsy may also have a physician that is not affiliated with the hospital or institution where the death occurred review the postmortem examination or autopsy conducted by a physician affiliated with the hospital or other institution where the deceased person died.

A person requesting a nonaffiliated physician to perform or review a postmortem examination or autopsy is responsible for any additional costs incurred as a result of the nonaffiliated physician's performance or review of the examination or autopsy.

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**SUPPLEMENTAL AUTOPSY CONSENT FORM AND RELEASE**

Name of deceased: \_\_\_\_\_

I (We) \_\_\_\_\_  
(name of nearest kin)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone number \_\_\_\_\_, bearing the relationship of \_\_\_\_\_

to the decedent named above, do hereby represent that I am (we are) entitled by law to control the disposition of the remains and authorize Autopsy and Pathology Services, P.A. and its doctors/representatives to release the body of the above named decedent, after completion of the autopsy, to the funeral home listed on the Postmortem Examination or Autopsy Consent Form.

I (We) authorize Jessie Adame, M.D. and Albert I. Chen, M.D. and any of their associates or consultants to perform an autopsy on the above decedent and authorize the removal, retention, examination and subsequent disposal of such organs, tissues and parts for diagnostic, scientific, academic or therapeutic purposes as the pathologist or his associates or consultants deem necessary and proper. This authority allows for a complete autopsy examination without restrictions to be performed unless a restriction or special limitation was specified on the Postmortem Examination or Autopsy Consent Form. **(NOTE: A COMPLETE AUTOPSY WITH NO RESTRICTIONS WILL BE PERFORMED IF NO RESTRICTION OR SPECIAL LIMITATION IS SPECIFIED.)**

I (We) also authorize the remains to be transported to the facility selected by Jessie Adame, MD and Albert I. Chen, M.D. and any of their associates or consultants in order to perform the autopsy.

I (We) understand that a prepayment of **TWO THOUSAND EIGHT HUNDRED DOLLARS (\$2,800.00)** plus any additional transport fees or toxicology fees is required before the autopsy is performed. Payment may be credit card, money order, or cashier's check payable to Autopsy and Pathology Services, P.A. This fee includes a detailed macroscopic and microscopic examination with typed report but does not include fees for services that are beyond the capabilities of this office (such as immunohistochemical stains, photography duplication, chemical laboratory studies, toxicology, electron microscopy, DNA studies, consultations with other specialists, etc.) Any extra costs for such services will only be done with prior approval of the legal next of kin. Further, this autopsy fee does not include any time which may be now or later requested of the pathologist(s) as a professional witness.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Printed Name: \_\_\_\_\_

**Order of Next of Kin**

- the spouse of the decedent;
- the person acting as guardian of the person of the decedent at the time of death or the executor or administrator of the decedent's estate;
- the adult children of the decedent;
- the parents of the decedent; and
- the adult siblings of the decedent

(Ref: Texas Code of Criminal Procedure Art. 49.32)

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**QUESTIONNAIRE PAGE 1 OF 2**

Name of deceased: \_\_\_\_\_

Address of deceased: \_\_\_\_\_ Zip \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of death: \_\_\_\_\_ Exact time of death: \_\_\_\_\_ a.m. p.m.

Place of death (include address): \_\_\_\_\_

\_\_\_\_\_  
Name of hospital/facility where deceased received treatment (if applicable): \_\_\_\_\_

\_\_\_\_\_  
Was the deceased: undergoing organ donation? \_\_\_\_\_ undergoing tissue donation? \_\_\_\_\_

Is the deceased: decomposed? \_\_\_\_\_ already embalmed? \_\_\_\_\_

Has an autopsy previously been performed on the deceased? (if so, by what facility or doctor (if known):

Why is an autopsy being requested? (Provide as much detail as necessary; you may use back of sheet or blank sheet):

Medical conditions which the deceased had (i.e. diabetes, high blood pressure, coronary artery disease, cancer including site of cancer if known, you may use back of sheet or blank sheet):

List of Medications deceased was taking:

Approximate height and weight of deceased (we need to know for transport purposes):

What funeral home is being used? (include contact person, address, phone and fax number):

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**QUESTIONNAIRE PAGE 2 OF 2**

**Name/Address/ phone number where report(s) should be sent** (if receiver is not Legal-next-of kin, then an Authorization To Release Protected Health Information Form MUST be completed):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Apartment number? \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

Phone #: \_\_\_\_\_

Do you want a PDF version of the report emailed to you? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide email address:

Your funeral director will need to assign a physician to certify the decedent's death certificate. **Do you want the pathologist who performs the autopsy to certify the death certificate?** YES \_\_\_\_\_ NO \_\_\_\_\_

(Please note: our pathologist cannot certify death certificates on decedent's who fall under the jurisdiction of a Medical Examiner's Office or a Coroner/Justice of the Peace or a stillborn infant. Additionally, our pathologist cannot amend a death certificate certified by another physician).

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**CREDIT CARD FORM**  
**Please print as neatly as possible**  
**COMPLETE ALL BLANKS EXCEPT CARD NUMBER**

AMOUNT CHARGED \$ \_\_\_\_\_

Card Type (circle one):    Visa    MasterCard    Discover    American Express

Card Number            IN ORDER TO BE IN COMPLIANCE WITH THE PAYMENT CARD  
INDUSTRY DATA SECURITY STANDARD (PCIDSS) PLEASE  
CALL OUR OFFICE WITH YOUR CARD NUMBER AT  
281-359-1953

Expiration Date \_\_\_\_\_

Card holder name (please print) \_\_\_\_\_

Address where card holder receives their monthly credit card statements:

Address: \_\_\_\_\_

City and State: \_\_\_\_\_

Zip code: \_\_\_\_\_

**I AGREE TO PAY ABOVE AMOUNT ACCORDING TO CARD ISSUER.**

Signature of Card Holder \_\_\_\_\_

Date signed: \_\_\_\_\_

**PLEASE WRITE NEATLY AND COMPLETE ALL LINES-DO NOT LEAVE ANY  
BLANKS!**