# List of Policies and Procedures Submitted to JCC for Approval on February 14, 2023

Blue (Hospital-wide); Grey (Departmental)

| Status | Dept. | Policy # | Title | Owner/ Reviser | Notes |
|---|---|---|---|---|---|
| **New** | MSPP | C01-02 | Autopsy Policy & Procedures Attachment - Autopsy Workflow and Required Forms | **D. Lovko-Premeau** | Attachment developed by LHH Medical Record Committee to assist the provider on the correct pathway. |

Laguna Honda and Rehabilitation Hospital

# HOW TO REQUEST AN AUTOPSY

## LHH Death Registry 415-759-3526

There is a standing agreement with Colma Cremation

| Provider Request | Family Request |
|---|---|
| Discuss autopsy consideration with family | Family requests, provider discusses option ***and family responsibility to cover any potential cost for transportation to ZSFGH*** |
| **Print and COMPLETE ALL Postmortem forms** and obtain family signature | **Print and COMPLETE All Postmortem forms** and obtain family signature |
| **Provider to Notify Mark Weinstein at ZSFGH in pathology of transport of deceased for autopsy**<br>Mark Weinstein Department Manager<br>Anatomic Pathology<br>Zuckerberg San Francisco General Hospital and<br>628/206-6068<br>628/206-5988 Fax<br>mark.weinstein@sfdph.org<br>(He may request form be faxed to him | **Provider to Notify Mark Weinstein at ZSFGH in pathology of transport of deceased for autopsy**<br>Mark Weinstein Department Manager<br>Anatomic Pathology<br>Zuckerberg San Francisco General Hospital and<br>628/206-6068<br>628/206-5988 Fax<br>mark.weinstein@sfdph.org<br>(He may request form be faxed to him) |
| **Provider Notify LHH Death Registry**<br>**Send Death Worksheet and postmortem form to LHH Death Registry** | **Provider sends Death Worksheet and postmortem form to LHH Death Registry** |
| **LHH Death Registry** (415-759-3526) **will notify ZSFGH and fax postmortem form**<br>Death Reg. Ph#: (628) 206-4316<br>Death/Birth Reg. Fax#: (628) 206-3070 | **LHH Death Registry** (415-759-3526) **will notify ZSFGH and fax postmortem form**<br>Death Reg. Ph#: (628) 206-4316<br>Death/Birth Reg. Fax#: (628) 206-3070 |
| **LHH Death Registry** will contact Colma Cremation (650) 343-3914 with information on where to pick up body and take for autopsy<br>(LHH Death registry will coordinate with ZSFGH)<br>Death Reg. Ph#: (628) 206-4316 | **LHH Death registry** with start the death registry process and transfer to funeral home.<br>Death Registry will provide contact for ZSFGH Morgue to the funeral home to make arrangements (contact ZSFGH (628)206-8000 contact Operator and ask for Morgue |

# Laguna Honda Hospital

## Health Information Management Services (HIMS)

*To be filled out by Certifying Physician

## Death Certificate Worksheet

| Name of Decedent- First (Given) | Middle | Last (Family) |
|---|---|---|
| | | |

| Date of Death | Hour |
|---|---|
| MM/DD/YYYY: | 24 Hour Time: |

| Cause of Death<br>Enter the chain of events – disease, injuries, or complications – that directly caused death, DO NOT enter terminal events such as cardiac arrest, respiratory arrest or ventricular fibrillation WITHOUT showing the etiology, DO NOT ABBREVIATE | Time Interval Between Onset and Death |
|---|---|
| Immediate Cause (Final disease or condition resulting in death)<br>(A) | (AT) |
| Sequentially, List conditions, If any, leading to cause on Line A<br>(B) | (BT) |
| Enter underlying cause (Disease or injury that initiated the events resulting in death) last<br>(C) | (CT) |
| (D) | (DT) |

| Death Reported to Coroner? | Biopsy Performed? | Autopsy Performed? | Used in Determining Cause? |
|---|---|---|---|
| ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO | ☐ YES ☐ NO |

| If Death was reported to Coroner: | Case/Referral Number (if applicable): |
|---|---|
| ☐ ACCEPTED ☐ DECLINE | |

**Other Significant Conditions Contributing to Death but not resulting in the underlying cause given (above):**

**Was Operation Performed for any condition(s) listed above (SPECIFY EXACT DATE and operation):**

**Physician's Certification**

| Decedent Attended Since (MM/DD/YYYY) | Decedent Last Seen Alive (MM/DD/YYYY) | Certifying Physician and Title: |
|---|---|---|
| | | License Number: |

**Place of Death will default as: Laguna Honda Hospital, 375 Laguna Honda Blvd. San Francisco, CA 94116.**
**IF OTHER, PLEASE SPECIFY:**

**After completion, please fax back to HIMS -Medical Records: (628) 217-7594**

San Francisco
Health Network
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

T-AD0003

NAME

DOB

MRN

PCP

Patient ID / Addressograph

# POSTMORTEM FORM

**Directions**: All sections of this form are REQUIRED. Call Death Registry at (628) 206-8015 with questions:

## SECTION 1: DEATH INFORMATION

Attending physician at time of death: _____ Pager #_____ CHN ID # _____

Death pronounced by (Print Name): _____ CHN ID # _____

Date of Death: _____(mm/dd/yy) Time of Death: _____(hh:mm) Service: _____

Cause of Death: Enter the chain of events – diseases, injuries, or complications – that directly caused death. DO NOT ABBREVIATE.
***NOTE: DO NOT enter terminal events or the mode of dying such as cardiac arrest, respiratory arrest, or ventricular fibrillation.***
***Please enter only ONE disease or condition for each line. You MUST include your best estimate of duration for each disease/condition.***

| | | |
|---|---|---|
| ***IMMEDIATE CAUSE*** → *(Final disease or condition resulting in death. Do NOT enter terminal events.)* | A. _____ | **Duration*:** _____ |
| ***DUE TO*** → *(Sequentially list conditions if any, leading to cause above.)* | B. _____ | **Duration*:** _____ |
| ***DUE TO*** → | C. _____ | **Duration*:** _____ |
| ***UNDERLYING CAUSE*** → *(Disease/injury that initiated the events resulting in death.)* | D. _____ | **Duration*:** _____ |

***(Example: hours, days, months, years)**

Other Significant Conditions contributing to death but not resulting in Underlying Cause of Death: _____

Did an operation/procedure precede death? ☐ No ☐ Yes
Operation/Procedure: _____ Date of operation: _____
Did an accident/fall/therapeutic complication occur during hospitalization? ☐ No ☐ Yes
Type of accident: _____ Date of accident: _____

## SECTION 2: FAMILY NOTIFICATION AND AUTOPSY INFORMATION

Family member or Legally Designated Representative notified: ☐ Yes ☐ No ☐ Unknown family or emergency contact

How: ☐ In person ☐ Telephone ☐ Police

Name of person notified: _____ Relationship: _____

Notified by: _____ Title: _____ CHN ID# _____

## SECTION 3: AUTOPSY INFORMATION

Autopsy requested? ☐ **Yes*** Consent of Legal Next of Kin granted. Include signed Autopsy Consent if patient has Next of Kin.
☐ **No** Consent for autopsy denied.
☐ **Pending** Consent for autopsy pending: ☐ Discussion with Next of Kin ☐ Written consent

MD Requesting Autopsy: *(Print Name)*: _____ CHN ID# _____

Consent obtained from: ☐ Legal Next of Kin/DPAHC *(Print Name)*: _____ Relationship: _____
☐ No known Next of Kin/DPAHC *(Requires verification by Death Registry)*

How was written consent obtained? ☐ Hospital Consent ☐ Advance Directive (copy required)
☐ Fax ☐ No known Next of Kin/DPAHC

- **ZSFG supports obtaining autopsies on all non-Medical Examiner cases.*
- *Consent for autopsy is required from Legal Next of Kin or DPAHC, unless it can be verified that there is none.*
- *Families should be informed that an autopsy may or may not be performed if the Medical Examiner accepts the case.*

**(OVER)**

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# POSTMORTEM FORM

## SECTION 4: MEDICAL EXAMINER NOTIFICATION

It is the LEGAL OBLIGATION of the physician to notify the Medical Examiner IMMEDIATELY of a reportable death. If there is doubt, call the Medical Examiner at (415) 641-2222.

| YES | NO | REPORTABLE CIRCUMSTANCES - CHECK YES OR NO FOR EACH AND SIGN BELOW |
|---|---|---|
| ☐ | ☐ | 1. All violent, sudden, or unusual deaths, or Deaths resulting from any suspected criminal act |
| ☐ | ☐ | 2. Suicides, Homicides, Strangulation, Gunshot Wound, Stabbing, Drowning, Burns, Hanging, Starvation |
| ☐ | ☐ | 3. Accidents and deaths relating to injury |
| ☐ | ☐ | 4. Falls |
| ☐ | ☐ | 5. Poisoning |
| ☐ | ☐ | 6. Acute Alcohol or Drug Use |
| ☐ | ☐ | 7. Contagious Diseases constituting a public hazard |
| ☐ | ☐ | 8. Death within 24 hours of hospital admissions |
| ☐ | ☐ | 9. Deaths within 5 days of any invasive procedure, or a therapeutic complication |
| ☐ | ☐ | 10. Unattended deaths (Patient has not been attended by a physician in the 20 days before death) |
| ☐ | ☐ | 11. All deaths in operating rooms, or when the patient has not recovered from anesthesia, whether in the OR, recovery room or elsewhere |
| ☐ | ☐ | 12. Death of patient who is comatose throughout hospital stay |
| ☐ | ☐ | 13. Death where physician is unable (NOT MERELY UNWILLING) to state cause of death |
| ☐ | ☐ | 14. Any Solitary/Unwitnessed Death |
| ☐ | ☐ | 15. Sudden infant death syndrome |
| ☐ | ☐ | 16. Known or alleged rape or crime against nature |
| ☐ | ☐ | 17. Self-induced or criminal abortion |
| ☐ | ☐ | 18. Occupational deaths |
| ☐ | ☐ | 19. Death of an unidentified person |
| ☐ | ☐ | 20. Death of a person in police custody or a prisoner |

Medical Examiner notified (415) 641-2222: ☐ No/Not Reportable ☐ Yes Date: (mm/dd/yy) Time: (hh:mm)

Notified by: _____ Title: _____ CHN ID#: _____

Case: ☐ Accepted** or ☐ Declined Accepted/Declined by: _____ Badge #: _____

**Tell the family if the Medical Examiner will be accepting the case. Autopsy may or may not be completed during the case review. This may affect the family's funeral planning.

## SECTION 5: DONOR NETWORK NOTIFICATION

Donor Network West notified***: Ref. #: _____ Date: (mm/dd/yy) Time: (hh:mm)

Notified by: _____ Title: _____ CHN ID#: _____

*** All deaths must be reported to Donor Network West (800) 553-6667

## SECTION 6: ADDITIONAL REQUIRED DOCUMENTATION

- ☐ Patient Discharge Plan (PDP) form
- ☐ Inpatient Death Note *(Date and Time of Death must be documented)*
- ☐ Authorization for Autopsy *(If applicable, and Next of Kin or DPAHC present and able to sign Consent form)*
- ☐ Discharge Summary within 24 hours *(Person Responsible: _____ /Pager: _____)*

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NAME

DOB

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# POSTMORTEM FORM
# AUTHORIZATION FOR AUTOPSY

**Directions:** All sections of this form are REQUIRED if an autopsy is to be performed. Call Death Registry at (~~415~~) 206-8015 (628) with questions:

**NOTE TO PROVIDERS:** Postmortem examinations will not be performed without written consent from Next of Kin* or DPAHC. **If the legal DPAHC or Next of Kin* is not present, do NOT have another family member sign this form.** If DPAHC or Next of Kin* verbally requests autopsy but is not present to sign this form, please advise him/her to contact the Death Registry at (~~415~~)(628) 206-8015 on the next business day. Other family may take a copy of this form and have the DPAHC or Next of Kin* fax the signed form to the Death Registry at (~~415~~) 206-3070. (628)

In the hope and with the expectation that this permission will contribute to the advancement of medical knowledge, I, as the next-of-kin or other person authorized by law to direct disposition, hereby authorize the performance of a postmortem examination by physicians of San Francisco General Hospital and Trauma Center, including removal and retention of such organs, or parts of organs, or tissue necessary for microscopic examination and subsequent study, use, or transplantation on the above named person.

This authorization shall be subject to the following restrictions:

_____

_____

- There is no additional cost to the family for an autopsy.
- Funeral arrangements can proceed as planned. Families who wish to have an open viewing can still do so.
- If the Medical Examiner accepts this case for review, autopsy may or may not be performed.

Date: (mm/dd/yy) Time: (hh:mm)

X _____ Print Name

X _____ **Signature of DPAHC or Spouse***

X _____ **If pt has no DPAHC or Spouse, Legal Next of Kin* (state relationship)**

X _____ Witness of Signature

X _____ Print Name

X _____ Witness of Signature

X _____ Print Name

X _____ Interpreter's Signature

X _____ Print Name _____ Interpreter ID #

## SECTION 7: DEATH REGISTRY PERSONNEL

**Authorization for Autopsy by Office of Curator of Unclaimed Dead**

Authorization received for autopsy on: _____ DATE

Authorization Number: _____

Authorization given by: _____

Signed: _____ DEATH REGISTRY PERSONNEL

***LEGAL Next of Kin, in order of priority, are:**
1) Durable Power of Attorney for Health Care (DPAHC)
2) Spouse/Registered Domestic Partner
3) Adult Child, 18 or over
4) Parent
5) Adult Sibling
6) Guardian
7) Other surviving relative

# Laguna Honda Autopsy Workflow