GOVERNMENT OF WESTERN AUSTRALIA

PathWest LABORATORY MEDICINE WA

Laboratory ID No

NCC FORM 3A

EMR400420

PathWest Perinatal Pathology
CONSENT FOR CREMATION AND MEMENTOS
MISCARRIED OR STILLBORN BABY LESS THAN 28 WEEKS GESTATION

Med Rec No: _____

Surname: _____

Given Name: _____

Gender: _____ D.O.B. : _____/_____/_____

Hospital: _____

Parent 1 First Name: _____ Surname: _____

Parent 2 First Name: _____ Surname: _____

Baby's Name _____ Surname: _____

Date of Delivery/Birth: _____/_____/_____ Gestation: _____/ 40

Preferred Contact Method: ☐ Text ☐ Phone call ☐ Email (please note if choosing Interment email is required)

Contact number: _____ Email:_____

There are 2 options for your baby's ashes after cremation. Please select option A OR option B.

☐ **A. Interment in the KEMH Memorial Garden**

I/we wish for my/our baby's ashes to be cremated and interred collectively in the KEMH Memorial Garden at the monthly Interment of Ashes Service.

Date of Service: _____/_____/_____

I/we wish for my/our baby's name to be read aloud at the Interment of Ashes Service: ☐ Yes ☐ No

Please Note: The service is held monthly on the last Thursday of the month except for Public Holidays and December. All parents external to KEMH will be sent/emailed a letter and brochure with the date, time and location of the Service in which your baby's ashes will be included.

☐ I/we do not wish to be sent/emailed a letter and brochure with the date, time and location of the Service.

☐ **B. Return of Separate Ashes**

I/we wish to collect my/our baby's ashes from the following place:

☐ Pastoral Care Services _____(hospital)

☐ KEMH PathWest Perinatal Pathology (Ph: 6458 2730)

☐ Hospital of origin (*Hospital agreement required with nominated staff contact's name and address provided).*

Name & Address: _____

_____

For multiple births: ☐ Combine ashes ☐ Individual ashes

Disclaimer: All ashes not collected within 12 months of signing this form will be interred in the King Edward Memorial Garden.

Mementos – If possible, mementos of your baby will be created and are available upon request unless declined.

Disclaimer: All belongings will be cremated with your baby unless otherwise stated below. Perinatal Pathology cannot be responsible for belongings not received. Please be aware that metals, hard plastics and large objects cannot be cremated.

Please select the mementos you would like to collect:

☐ Photos ☐ Hand & Footprints

☐ Belongings to be returned

(please state which belongings you would like returned):

_____

Please select your collection preference:

☐ I will collect with Separate Ashes **or** at the Internment Service

☐ I will contact Perinatal pathology to collect

☐ Please Post to my home address

Decline of mementos: I understand that by declining the mementos below, they will not be taken and will not be available to me.

☐ I do not give permission for **Photos** to be taken of my baby.

☐ I do not give permission for **Hand & Footprints** to be taken of my baby.

Any Special Instructions (e.g. hold cremation until after viewing etc.):

DISCLAIMER: Perinatal Pathology will NOT cremate your baby before three (3) calendar days of this Form being signed and dated.

After discussion of the above cremation options with Pastoral Care (and/or appropriate staff member),

I/we _____ hereby request PathWest Perinatal Pathology to cremate my/our baby at King Edward Memorial Hospital.

Full Name: _____ Signature: _____

Witness Name: _____ Witness Signature: _____

Date: _____/_____/_____ Time: _____:_____ AM/PM (Witness must be a staff member)

Verbal Consent: I, _____ (must be a staff member), hereby declare that the parents of baby _____ have given their **verbal consent** for cremation as indicated above.

Signature: _____ Date: _____/_____/_____ Time: _____:_____ AM/PM