

REQUEST FOR PLACENTA

(1) REQUEST BY PATIENT:

I hereby request that following the birth of my child, my placenta be:

- Returned to me (name) _____
- Released to my designee (name) _____

Acknowledgement of risk of potential infection:

I understand that my test findings are negative for HIV 1 and 2, Hepatitis B, and Hepatitis C. However, I acknowledge that no test can completely ensure the absence of infectious agents and accept any risk of infection to myself and others who handle this placenta.

Name of woman

Signature of woman

Date

(2) ATTESTATION OF PHYSICIAN:

I hereby certify that _____ has been tested for the following:

	Date of Test	Test Result
<input type="checkbox"/> HIV 1 and 2	_____	_____
<input type="checkbox"/> Hepatitis C	_____	_____
<input type="checkbox"/> Hepatitis B	_____	_____
<input type="checkbox"/> Other _____	_____	_____

The test findings and medical information available to me at this time indicate the absence of maternal communicable diseases. The placenta may be released pursuant to Act 12.

Name of physician

Signature of physician

Date

(3) HOSPITAL INFORMATION:

The above woman delivered an infant on _____ (date). Upon negative findings in the mother as attested to by the above physician, the placenta was released to:

_____ on _____.
(person receiving placenta) (date)

Hospital authority

Date

Name of Hospital: _____ Phone: _____