

# 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 \_\_\_\_\_

\_\_\_\_\_  
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: \_\_\_\_\_