



Authorization for Fetal Studies and Dispatch
(Please send this completed form with the specimen)

To be filled out for all specimens regardless of gestational age.

We (I), _____ the parent(s) of
_____, delivery date _____, hereby permit release to the Department of
Medical Genetics at Shodair Children's Hospital, Helena, MT, for limited fetal pathology studies (external exam, no
removal of organs) and chromosome studies as indicated below:

Check from the following:

Table with 2 columns: PROCEDURE and COST OF SERVICE. Rows include: Limited Fetal Pathology (external exam) \$241, Cytogenetic studies only \$887, Limited Fetal Pathology (external exam) and Cytogenetics \$1,128, Molecular (DNA) studies if required Please inquire.

Further, I authorize: (Check only one box)

- The return of the remains to _____ (mortuary) or _____ Hospital Laboratory
Shodair Children's Hospital to dispose of the remains. (applies only to <20 weeks gestation)
Cremation and return of ashes to: (May apply to any gestational age) _____
Cremation without return of ashes. (Applies only to ≥ 20 weeks gestation)

Please Note: There is a \$75.00 (<20 weeks) or \$100.00 (≥ 20 weeks) charge for cremation of fetal material.

* A detailed price list is available.

I understand that I should contact my insurance provider (including Medicaid) for coverage of these services and that I am financially responsible for charges not covered by insurance.

Mother's signature

Father's signature

Witness

Witness

A genetic counselor is available to speak with you about your loss and answer questions about laboratory services.
Please contact the Medical Genetics Department at Shodair Children's Hospital by calling toll-free 1-800-447-6614.
(This form may be photocopied).