CONTACT INFORMATION SHEET

DECEDENT'S NAME: _____ PATIENT STICKER

DECEDENT'S DATE OF BIRTH: _____

PATHOLOGIST FROM REFERRING HOSPITAL:

NAME:_____

ORGANIZATION/HOPSITAL NAME:_____

PHONE:_____ FAX:_____

EMAIL:_____

OBSTETRICIAN FROM REFERRING HOSPITAL:

NAME:_____

ORGANIZATION/HOPSITAL NAME:_____

PHONE:_____ FAX:_____

EMAIL:_____

BILLING INFORMATION:

ORGANIZATION/HOPSITAL NAME:_____

ADDRESS:_____

STATE:_____ ZIP CODE:_____

PHONE:_____ FAX:_____

INVOICE EMAIL ADDRESS: _____

RELEASE OF BODY INFORMATION (WHO TO CONTACT AFTER AUTOPSY IS COMPLETE) :

NAME/FUNERAL HOME:_____

PHONE NUMBER:_____ FAX_____

*CCHMC Pathology Department does not charge families or their insurances for autopsies. All billing information must be provided before transportation of decedent.

Updated: 4/2025