



Fetal Death Disposition-Notification Form

Time given to mother _____ a.m. / p.m.

This form shall be used to notify a mother of her disposition rights and options after experiencing a spontaneous fetal demise of less than 20 completed weeks of gestation [See Hospital Licensing Act (210 ILCS 85/11.4)].

I, _____, understand that within 24 hours of reading this notification, have the right to arrange for the burial or cremation of these remains, or choose to let the hospital handle the disposition under the terms and conditions that the hospital may prescribe.

My signature commits me to one of the following two options.

Please check **one**:

1. _____ I elect to have the hospital handle the disposition of these remains under the terms and conditions that it may prescribe. The hospital can explain the costs for this service, if any.
2. _____ I elect to contact a funeral director of my choice and arrange for the burial and/or cremation of these remains at my expense.

My failure to sign this form within 24 hours of reading it authorizes the hospital to handle the disposition under the terms and conditions customarily used by the hospital.

Mother's signature

Date

Witness' signature

Date

For Official Use Only

This section shall be used by medical or hospital personnel to indicate the manner and the cause of death (see instructions sheet). For information about the need to issue a fetal death certificate, please see Vital Records Act (410ILCS535/21.5).

Manner of death: ☐ Natural ☐ Accident ☐ Homicide ☐ Could Not Be Determined

Cause of death _____

Signature of medical or hospital personnel completing this part

Date