Date Given to Patient: _____/__ ___/_____

Time Given to Patient: _____:_____a.m. / p.m.

Notice:

You have the option to bury or cremate the remains after miscarriage but you must complete and return this form to this health facility within forty-eight (48) hours to elect this option.

Louisiana law requires this form to be given to you to inform you of your right to arrange for the final disposition of fetal remains resulting from a miscarriage. **Please read carefully.**

You are only required to sign and return this form if you would like to make arrangements for the burial or cremation of the fetal remains. If you do not sign and return this form the health facility will be allowed to make final disposition of the remains according to state law.

By signing and returning this form, you are choosing to make arrangements for the final disposition of the remains and agree to the following:

(1) I understand that Louisiana law requires me to return this completed and signed form to the location listed below within forty-eight (48) hours of the health facility providing me the form. Failure to return the form within forty-eight hours will allow the facility to make final disposition of the remains according to state law. Return the form to:

(2) I understand that the health facility will notify me, or my designee (which may be a funeral home) that the fetal remains may be obtained from the facility within seventy-two (72) hours from the time the facility notifies me or my designee. Failure to pick up the remains within seventy-two (72) hours will allow this health facility to make final disposition of the remains according to state law.

Please provide below your contact information and the contact information of your designee, if you choose, who will be taking possession of the remains.

Patient/Spouse/Guardian Name: _____

Street Address:_____

City: _____ State: _____ Zip:_____

Telephone Number: (____) _____

Email Address (optional): _____

Designee/Funeral Home Name: _____

Street Address:_____
City: _____ State:_____ Zip: _____
Telephone Number: (____)_____

(3) I understand that choosing to arrange for the final disposition of the fetal remains is at my expense and it is my responsibility to ensure that the final disposition of the fetal remains is in accordance with Louisiana law.

I have read and understand the information presented to me on this form and my signature indicates my desire to arrange for the final disposition of the fetal remains.

_____	_____	_____
Patient/ Spouse/ Legal Guardian (Print or Type Name)	Signature	Date

(Facility Use Only)

Date Form Is Returned to Facility: _____/_____/_____
Time Form Was Returned To Facility: _____:_____ a.m /p.m.
Signature of Facility Representative: _____

You may inquire about the chaplain or other counseling services that may be offered by this facility. Other counseling options can located on the Louisiana Department of Health website at www.ldh.la.gov .

This notice of parental rights form is required to be provided to you by Louisiana law.