POLICY: FORMAT OF AUTOPSY REPORTS

**Policy:**

Autopsy reports are prepared by the examining pathologist for every autopsy performed. The narrative report is dictated upon completion of the postmortem exam. Typed reports present in a standard format and are signed by the pathologist who performed the postmortem examination. The records of autopsy examinations are made available to parties as identified in the Sec. 19a-401-12 of regulations established by the Commission on Medicolegal Investigations.

**Procedure:**

1. The pathologist will prepare a narrative report for each autopsy examination, upon completion of the exam, which includes:
2. the case number;
3. the name of deceased, if known;
4. the date, place, and time of examination, and names of observers from outside the agency (when applicable);
5. the name of other OCME Medical Examiners present at the time of examination.
6. observations of the clothing and personal property, external examination and internal examination (when performed);
7. a description of internal and external injuries (remarking when none are found);
8. a statement whenever a major organ (heart, brain) is retained after autopsy for further study either by OCME personnel or a consultant.
9. Narrative reports are dictated into a pathologist's digital recording device.
10. The device loads the recording into the pathologist's personal computer, and specific software allows transmission of digital recording to off-site contracted transcription service.
11. Transcription service transcribes the dictation and electronically transfer to OCME.
12. Medical Secretaries download the drafts daily and save a copy to our Intranet folder.
13. Reports are reviewed and amended, if necessary.
14. Written notes taken and/or diagrams prepared during autopsy are filed by the examining pathologist in the case folder.
15. Final, typed autopsy reports are signed and dated by the examining pathologist. The standard format for the report includes:
16. the name and title of the examining pathologist;
17. the information listed in #1.a)-1.f) above;
18. descriptions of findings to support diagnoses, opinions, and conclusions; specifically including an Injuries section.
19. toxicological test results and results of other examinations or consultations
20. a list of the diagnoses and interpretations identified in the reports;
21. cause and manner of death.
22. The regulations of the Commission on Medicolegal Investigations make the autopsy report available to:
23. the family of the deceased;
24. state or municipal government agencies or a public health authority investigating the death;
25. insurance companies with a legitimate interest in the death;
26. all parties in civil litigation proceedings;
27. all physicians who treated the deceased.