RUSH MEDICAL CENTER DEPARTMENT OF NEUROLOGY
SECTION OF MOVEMENT DISORDERS
CHECKLIST FOR BRAIN AUTOPSY REQUEST

1. **PATIENT INFORMATION**
   Name: _____
   Phone number: _____
   Address: _____
   _____

2. **FAMILY CONTACT PERSON**
   Name: _____
   Phone number: _____
   Address: _____
   _____

3. **FAMILY PHYSICIAN** (the doctor to be notified in the event of death)
   Name: _____
   Phone number: _____
   Address: _____
   _____

4. **FUNERAL DIRECTOR**
   Name: _____
   Phone number: _____
   Address: _____
   _____

5. **PATHOLOGIST** (if out of town)
   Name: _____
   Phone number: _____
   Address: _____
   _____