



6816

Authorization for Liver Transplant

Patient's Name: _____

I hereby authorize Dr. _____ to perform the following surgery:

I understand that residents, medical students, physician assistants and/or advanced practice registered nurses may also be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified surgery. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery: (i) the nature and purpose of the proposed surgery; (ii) the foreseeable risks and consequences of the proposed surgery, including the risk that the proposed surgery may not achieve the desired objective; (iii), the alternatives to the proposed surgery and the associated risks and benefits to such alternatives; and (iv) the reasonably foreseeable risks and alternatives to the transfusion of blood and blood products should I need a blood transfusion.

I have been informed of the Hartford Hospital Transplant Center's most recent SRTR data, my right to refuse transplant or treatment and the specific risks associated with the organ I am to receive.

Specifically, in obtaining my informed consent to the surgery, I have been informed of the following reasonably foreseeable risks:

- Bowel obstruction or perforation
- Liver organ non-function
- Liver organ poor function
- Bile duct leak or narrowing
- Bleeding
- Possible need for re-transplant and reoperation
- Anesthesia risks
- Need for transfusion of blood products
- Clotting of liver blood vessels
- Blood clot in lungs or legs
- Recurrent disease in new liver
- Death
- Pneumonia
- Heart attack
- Wound infection
- Systemic infection
- Fluid Collection

There is no comprehensive way to screen potential donors for all transmissible diseases and on occasion, infectious agents, donor-associated tumors or genetic diseases may be identified after transplantation.

_____ Patient initial



6816

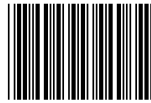
The liver we are offering you is considered an Expanded Criteria donor liver for the following reasons:

- Donor over age 65
 - Fatty liver- greater than 30% macrosteatosis
 - Segmental liver graft (liver split into 2 segments)
 - Hepatitis C positive serology –NAT negative
 - Hepatitis C positive serology – NAT positive
 - Hepatitis B positive serology (HBV core antibody)
 - Central nervous system cancer or history of other non-skin cancer
 - ABO Incompatible donors
 - Other (Describe): _____
- _____

_____Patient initials

If my transplant will be from a living donor, I have been informed and understand the risks, benefits and complications specific to a partial living donor transplant.

_____Patient initials



6816

I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed surgery. All of my questions have been answered to my satisfaction.

I agree to the use of anesthesia and/or sedation/analgesia as required, and if applicable, the disposal of any tissue removed.

I also authorize the Hospital and the above-named physician(s) to photograph, video and /or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

MD/APRN/PA Signature

Printed Name of MD/APRN/PA

(Patient or legally authorized representative)

Printed name of Patient or legally authorized representative

Date: _____ Time: _____

Date: _____ Time: _____

Interpreter responsible for explaining: _____
Printed name of interpreter

Interpreter signature

Date: _____ Time: _____

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [] BECAUSE:	

_____ M.D.	Date: _____ Time: _____
_____ Witness	Date: _____ Time: _____