Authorization for Kidney Transplant (recipient)

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. These individuals will be performing tasks that are within their scope of practice, as determined under State law and regulation, and for which they have been granted privileges by the hospital. 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 benefits to the proposed surgery/procedure/treatment; (iv) the alternatives to the proposed surgery and the associated risks and benefits to such alternatives; and (v) 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
- Anesthesia risks
- Pneumonia
- Donor organ non-function
- Possible need for dialysis
- Heart attack
- Donor organ poor function
- Wound infection
- Rejection
- Blood clot in lungs or legs
- Systemic infection
- Bleeding, fluid collection
- Organ transplant technical complications of blood vessels or ureter
- Possible need for re-transplant and reoperation
- Death
- Death

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
The Public Health Service -2020 has identified certain organs as being at higher risk of transmitting infectious disease when they are used for transplant. Receiving any donor organ carries a risk of receiving an organ with compromised function and/or the transmission of diseases despite appropriate screening and negative findings. These infectious diseases include but are not limited to human immunodeficiency virus (HIV), Hepatitis C (HCV) and Hepatitis B (HBV).

The kidney we are offering you meets the Public Health Service (PHS) Particular risk criteria (2020) for the following reasons (check all that apply).

☐ Not Applicable

☐ Chagas Disease -Recent travel of donor or donor originally from South America with risk of exposure to Trypanosoma Cruzi

☐ People who have had sex with a person known or suspected to have HIV, HBV or HCV infections in the preceding 3 months

☐ Men who have had sex with other men in the preceding 3 months.

☐ Persons who report non-medical intravenous, intramuscular or subcutaneous injection of drugs in the preceding 3 months

☐ People who have engaged in sex in exchange for money or drugs in the preceding 3 months.

☐ People who have had sex with a person who had sex in exchange for money or drugs in the preceding 3 months.

☐ People who have had sex with a person that has injected drugs by IV, IM or sub-Q route for non-medical reasons in the preceding 3 months.

☐ People who have been in lockup, jail, prison, or a juvenile correctional facility for more than 72 hours in the preceding 3 months.

☐ A child who is ≤ to 18 months of age and born to a mother known to be infected with HIV, HBV, or HCV infections.

☐ A child who has been breastfed within the preceding 3 months and the mother is known to be infected with HIV, HBV, HCV infection.

☐ When a deceased potential organ donor’s medical/behavioral history cannot be obtained or risk factors cannot be determined, the donor should be considered at increased risk for HIV HBV and HCV infection because the donor’s risk is unknown.

___________ Patient initial
☐ The kidney we are offering you is considered a KDPI >85% donor kidney for the following reasons (check all that apply):

☐ Donor age
☐ Height
☐ Weight
☐ Ethnicity
☐ History of hypertension
☐ History of diabetes
☐ Cause of death
☐ Elevated creatinine (blood test that reflects kidney function)

____ (Patient Initials)

☐ The kidney we are offering you has positive donor serologies

☐ Hepatitis C (HCV) Positive serologies

  • HCV Antibody +/- HCV NAT - (remote infection, 16% estimated risk of disease transmission)
  • HCV Antibody +/- HCV NAT + (active infection, 100% estimated risk of disease transmission)

☐ Hepatitis B Positive serologies

  • HBVcAb + (chronic infection)
  • HBV sAg + and/or HBV NAT + (active infection)

☐ Other (Describe): _________________________________________________________________

______________________________________________________________

____ (Patient Initials)
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 risks and 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.

Having read this form and talked with my physician, my signature acknowledges that I voluntarily give my authorization and consent to the performance of the surgery/procedure/treatment described above.

_________________________________________ M. D.  Signed: ____________________________________________
(Patient or legally authorized representative)

Date:___________ Time:___________  Date:___________ Time:___________

Interpreter responsible for explaining:

_________________________________________ (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [ □ ] BECAUSE:

_________________________________________ M.D.  Date:___________ Time:___________

_________________________________________ Witness  Date:___________ Time:___________