Hartford HealthCare
Hartford Hospital

2400

Patient Name_____
MRN_____
ACCT Number_____

Informed Consent for Kidney Transplant

Patient's Name: _____

I hereby authorize Dr._____to perform the following surgery on me:

_____

_____

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
- Donor organ poor function
- Blood clot in lungs or legs
- Possible need for dialysis
- Wound infection
- Systemic infection
- Heart attack
- Rejection
- Bleeding, fluid collection
- Organ transplant technical complications of blood vessels or ureter
- Possible need for re-transplant and reoperation
- 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 initials_____

The **Public Health Service (PHS)** has identified certain organs as being at particular 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 is from a donor who, within the 30 days before organ donation, met the PHS risk criteria for one of more of the following reasons:

- Sex (i.e., any method of sexual contact, including vaginal, anal, and oral) with a person known or suspected to have HIV, HBV or HCV infection;
- Man who has had sex with another man;
- Sex in exchange for money or drugs;
- Sex with a person who had sex in exchange for money or drugs;
- Drug injection for nonmedical reasons;
- Sex with a person who injected drugs for nonmedical reasons;
- Incarceration (confinement in jail, prison, or juvenile correction facility) for ≥ 72 consecutive hours;
- Child born to a mother with HIV, HBV or HCV infection;
- Child breastfed by a mother with HIV infection; or
- Unknown medical or social history

☐ Not Applicable

Patient initials_____

☐ The kidney we are offering you is considered a **KDPI >85%** donor kidney.

The Kidney Donor Profile Index (KDPI) combines a variety of donor factors into a single number that tells you how long a deceased donor kidney is expected to function relative to all of the kidneys recovered in the U. S. during the last year. Donor factors considered include age, height, weight, type of death, history of high blood pressure, history of diabetes, and serum creatinine.
Lower KDPI scores are associated with longer estimated function, while higher KDPI scores are associated with shorter estimated function.

☐ Not Applicable

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☐ The kidney we are offering you has the following **positive donor serologies:**

☐ Hepatitis C (HCV) positive serologies
- ☐ HCV Antibody positive / HCV nucleic acid testing (NAT) negative (remote infection)
- ☐ HCV Antibody positive / HCV NAT positive (active infection)

☐ Hepatitis B (HBV) positive serologies
- ☐ HBVcAb positive (chronic infection)
- ☐ HBVsAg positive and/or HBV NAT positive (active infection)

☐ Other (Describe): _____

☐ Not Applicable

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.

I may revoke this consent 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.

Patient or Legally Authorized Representative (signature)		Date	Time
Telephone/Verbal Consent obtained from (print full name)		Date	Time
Relationship if not patient	☐ Official Interpreter Signature or ID #		
Resident/Fellow/Advanced Practice Provider (APP) Signature	Resident/Fellow/APP (Print full name)	Date	Time
ATTENDING Physician Signature	ATTENDING (print full name)	Date	Time
Witness (Provider or RN) Signature - mandatory for telephone consent		Date	Time