

Authorization for Living Partial Hepatectomy for Organ Donation

Patient's Name: _____

I hereby authorize **Drs.** _____ to perform the following surgery:
(Right / Left) Partial Hepatectomy for organ donation and cholecystectomy.

I understand that, residents, medical students, physician assistant and 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 reasonably 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 reasonably associated risks and benefits to such alternatives; (iv) the reasonably foreseeable risks to the transfusion of blood and blood products should I need a blood transfusion. Specifically, in obtaining my informed consent to the surgery, I have been informed of the following reasonably foreseeable risks:

- | | |
|--|--|
| ☐ Anesthesia risks | ☐ Bleeding requiring red blood cell or other blood product transfusions |
| ☐ Technical complications with blood vessels or bile duct leaks or strictures that may require intervention | |
| ☐ Ileus, bowel obstruction or perforation | ☐ Arrhythmias |
| ☐ Cardiovascular collapse | ☐ Heart attack |
| ☐ Diaphragmatic perforation or splenic injury | ☐ Aborted procedure |
| ☐ Death during or after surgery | ☐ Blood clot in lungs or legs |
| ☐ Organ failure in the remaining liver segment requiring urgent listing for liver transplant | |
| ☐ Transient liver dysfunction with recovery | ☐ Pain and fatigue |
| ☐ Fluid collection | ☐ Pneumonia |
| ☐ Hernia development | ☐ Bloating and/or nausea |
| ☐ Wound/systemic infection | ☐ Nerve injury |
| ☐ Adhesions | ☐ Scars |
| ☐ There may be other consequences typical of any surgical procedure | |

I am aware that, in addition to the reasonably foreseeable risks described, that 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 surgery, that no guarantee has been made to me as to the results that may be obtained, that an offer has been made to me to answer any of my questions about the proposed surgery.

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 Hartford Hospital so long as the manner of disposition shall be permanent destruction.

Special Procedure/Treatment for Living Partial Hepatectomy for organ donation

I have been informed that in addition to the portion of my liver that I am donating, that partial removal of the following vessels may occur: hepatic artery, hepatic vein, portal vein, and bile duct. These vessels and the bile duct may only be used for the implantation or modification in my intended recipient. I have also been informed that my gallbladder may be removed as part of the donation surgery.

If an unforeseeable complication should arise, and my donated liver segment is not able to be implanted into my intended recipient, I wish to have my liver segment (check appropriate box):

- ☐ Discarded
- ☐ Donated to a liver recipient on the Hartford Hospital waitlist
- ☐ Donated to a liver recipient on the UNOS national list

_____ **Patient initial**

☐ Current Recipient SRTR Data has been reviewed with me and I have received a copy.

I reaffirm that I am willing to donate a portion of my liver and free from inducement or coercion. I understand I am free to change my mind about donation at any point prior to anesthesia and that this consent may be revoked by me at any time, except to the extent it has already been relied upon.

Signature (Patient or legally authorized representative) Signature (MD, APRN, PA)

Date_____ Time:_____ Date_____ Time:_____

Interpreter responsible for explaining procedures and special treatment:

_____ (Interpreter)

UPDATED CONSENT AND VERIFICATION OF SURGEON PERFORMING PROCEDURE:

Signature (MD, APRN, PA) Signature (Patient or legally authorized representative)

Date_____ Time:_____ Date_____ Time:_____