

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

RUSH UNIVERSITY MEDICAL CENTER

**SOLID ORGAN TRANSPLANT  
INFORMED CONSENT**

Reg/Admin-E

Solid Organ Transplant Informed Consent



IDN13150339

1. I hereby authorize \_\_\_\_\_ and/or \_\_\_\_\_ and/or such assistants and associates as may be selected by him/her/they to perform the following procedure(s)/treatment(s) upon myself/ the patient.

Procedure(s)/Treatment(s) \_\_\_\_\_

**Yes No**

**Donor Associated Risk Factors:** If yes, the following donor associated risk factors have been identified:

The potential risks of accepting this specific organ with these risk factors have been explained to me. My signature below indicates I have been notified of this risk by my transplant team and I wish to proceed with the transplant.

**Yes No**

**CDC High Risk Donor Transplant:** I understand that the donor for my transplant has been tested for Human Immunodeficiency Virus (HIV) and these tests are all negative. I also understand that even though these tests are negative, the donor is considered to be at an increased risk for transmitting Human Immunodeficiency Virus (HIV) based on guidelines established by the Center for Disease Control (CDC). I acknowledge that I have read this document and the information sheet entitled: **CDC High Risk Donor Information Sheet & Transplantation Patient Information Sheet** and that I fully understand them. My signature below indicates I have been notified of this risk by my transplant team and I wish to proceed with the transplant.

2. I understand that this procedure(s)/treatment(s) appears indicated by the diagnostic and/or clinical observations performed. I have been informed of the following:

- A description of the proposed procedure/treatment
- The indications for the proposed procedure/treatment
- Material risks and benefits for the patient related to the treatment based on the available clinical information and dependent upon the professional custom and standard.
- The likelihood of the patient achieving his or her goals.
- Treatment alternatives, including the attendant material risks and benefits
- The probable consequences of declining the recommended or alternative therapies
- Who will provide the procedure/treatment
- When indicated, any limitations on the confidentiality of information learned from or about the patient

I understand the information provided and give this consent voluntarily.

3. I authorize the administration of blood and blood products to myself/the patient as may be considered necessary or advisable in connection with the above described procedure(s)/treatment(s) both during the procedure and for the remaining period of hospitalization of myself/the patient. I have been informed of the potential benefits, risks or alternatives to receiving blood and blood products.

4. I authorize the administration to myself/the patient of anesthetics determined to be necessary or advisable by the physician responsible for administering or for supervising the administration of anesthetics. I acknowledge that I have read and fully understand the patient information sheet provided me about anesthesia services or have otherwise been fully advised about, and understand, the nature and purpose of the anesthesia, the possible risks and complications and possible alternative anesthesia methods.

5. I have informed the licensed health care provider that to my knowledge I have allergies to the following substances and drugs:  
(If none, leave blank) \_\_\_\_\_

6. I understand that some physicians who may be treating me or the above-noted patient are not employees or agents of Rush University Medical Center but are independent medical practitioners who are solely and exclusively responsible for the exercise of their medical judgment.

7. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of the aforementioned procedure(s)/treatment(s).

(OVER)

