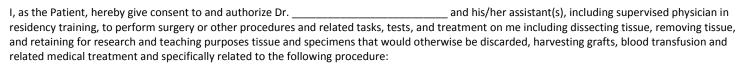
## CONSENT FOR SURGICAL AND MEDICAL TREATMENT AND BLOOD TRANSFUSION (LIVING KIDNEY DONOR)

Living Donor Surgery Consel

PATIENT LABEL HERE

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□ Left □ Right laparoscopic living kidney donation surgery and such additional procedures or treatment as are considered advisable on the basis of findings during the course of this procedure(s), including conversion to open nephrectomy. The physician performing the procedure or designee has explained to me the purpose and benefits of and the usual and most frequent risks and hazards involved in such procedures and treatment, including but not limited to the following:

Laparoscopic donor nephrectomy is a major operation and carries the same potential for complications as any other operation. These potential risks include:

- Death h. Nerve injury a. Anesthetic risk b. Heart attack Heart failure Bleeding c. j. Allergic reaction d. Infection Difficulty breathing I. **Blood clots** e.
- f. Hernia
   m. Temporary artificial ventilation
   g. Temporary incisional pain
   n. Other complications

Other foreseeable side effects after the operation include:

- a. Nausea
- b. Prolonged need for bladder catheterization
- c. Unusual taste in the mouth
- d. Psychosocial risk of depression

## Long term limitations of living with one kidney:

There are no known long term health risks associated with living kidney donation. There is no measureable increase in the likelihood of subsequent kidney failure that has been measured in patients with one kidney. There have been isolated instances of patients who subsequently developed renal failure after donating a kidney, and as a consequence required dialysis. There are certain limitations that anyone with one kidney should consider prudent including:

- a. Avoiding dehydration
- b. Avoiding non-steroidal anti-inflammatory medicines
- c. Alerting medical personnel to your status as a past donor before taking any medication including prescription drugs, over-the-counter medications and natural or herbal remedies
- d. There are no benefits of this procedure to you from having the operation

I am aware that these are the usual and most frequent risks and hazards. I am also aware that other risks and hazards are possible, some of which may be life-threatening. I am aware that I may opt out of donation at any time during the donation process.

Medical sciences cannot produce guaranteed results and no guarantees have been made to me concerning the results of my donation surgery or postsurgical care. I am aware that any future health problems I may have related to the donation may not be covered by my insurance. I have been counseled about the long term effects and benefits of the procedure and this has been done with the surgeon and the transplant coordinator.

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I understand that some medical care will be provided by the physicians and others employed by the hospital; some care may be provided by physicians at their own private practice. Anesthesiology, Radiology and Pathology services and many other medical specialty services are provided by physicians and other clinicians who are not employed by MMC but are authorized to provide care at the hospital as members of their own private practices. My primary care physician and my treating physicians can explain on request my options for selecting treating physicians at the hospital or at another facility. I understand that the hospital is a teaching hospital and authorized physicians and trainees may observe or assist in diagnosis and treatment. Images may be made to share with consulting physicians or for research and teaching, while using reasonable efforts to avoid identifying me.	
☐ DO NOT make images of me for teaching or research.	
BLOOD PRODUCTS	
to treat conditions arising during this hospital stay. Mild reactions su	, platelets, cryoprecipitate) may be necessary or appropriate as part of my care, or uch as fever and hives are quite common. Despite testing, the risk of an extremely lung injury, and death. Under some clinical situations and with appropriate discussion of the risks and alternatives has been offered.
I hereby consent to surgery, treatment, and blood products unless the "decline blood products" box is checked below	
☐ DECLINE BLOOD PRODUCTS	
	entative may observe the procedure to provide technical information or gain sentative will not "scrub" or use devices but will have minimal information about the "decline representative presence" box is checked below.
Signature of Patient or Authorized Representative	Date   24H Time
Signature of Physician or Designee	Date   24H Time
If consent is obtained by telephone, the following must be complet  1. Name of person giving consent and relationship to patient	
2. Name of third party witness phone number (Please print):	Phone Number:
3. Signature of third party witness:	DATE/TIME
4. Signature of Physician   Designee:	DATE/TIME
Use of interpreter or Special Assistance  If consent is obtained by use of an interpreter or special assistance, to provide the special assistance and the special assistance and the special assistance and the special assistance, to provide the special assistance, to provide the special assistance, to provide the special assistance and the special assistance are special assistance and the special assistance and the special assistance are special assistance and the special assistance and the special assistance and the special assistance are special assistance and the special assistance and the special assistance are special assistance and the specia	
Interpretation provided by	