INFORMED CONSENT FORM
Willing to Accept a Donor Offer with Increased Risk of Disease Transmission

Patient Label

1. I understand that receiving an organ carries a risk of disease including but not limited to bacterial or viral infection (e.g. hepatitis C) and cancer. Some organ donors have a higher risk of transmitting infectious diseases than other donors. These donors are called increased risk donors.

2. I understand that testing of donors for diseases has limitations. I understand that some of these diseases may not be identified until after my transplant has occurred (e.g. the donor had an unrecognized bloodstream infection). I may need to be monitored after my transplant as a result. If appropriate, I may be offered treatment or see specialists about this.

3. I understand that I may be offered an organ from an increased risk donor. This will be because my transplant doctor feels the benefit of accepting this organ outweighs the risk. The specific benefits and risks of taking this organ will be explained to me at the time of transplantation. I can refuse the organ and my status on the waiting list will not be affected.

4. I have been provided with a copy of the Patient Information Guide – *"Risk of Disease Transmission from Organ Donors"*. I understand that I can ask a transplant nurse or physician about any questions that I may have on infectious disease from donors at any time to assist me in making an informed decision.

I understand the above and would be willing to be offered an organ from an increased risk donor.

Name: (Mr., Mrs., Ms.) _____
SURNAME GIVEN NAMES

SIGNATURE: _____ _____
(PATIENT OR GUARDIAN) (PRINT NAME IF NOT THE PATIENT)

_____ DATE:_____
(Relationship to Patient if not the Patient)

WITNESS:_____ _____
(SIGN) (PRINT NAME)

DATE:_____

STATEMENT BY PROFESSIONAL INTERPRETER
COMPLETE **ONLY** IF A PROFESSIONAL INTERPRETER IS USED TO OBTAIN CONSENT.
I have translated the above information to the: _____Patient/Client ____parent ___legal guardian or representative and I have interpreted their responses to the health care provider.

_____ _____ _____
SIGNATURE OF INTERPRETER PRINT NAME DATE SIGNED