INFORMED CONSENT FORM
Willing to Accept a Donor Offer from HCV NAT-Positive Donors

Patient Label

1. I understand that I may be offered an organ from a donor with hepatitis C infection (HCV NAT-positive). 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 have been explained to me and will be discussed again at the time of transplantation. I can refuse the organ and my status on the waiting list will not be affected.
2. I understand that receiving an organ from a hepatitis C infected (HCV NAT-positive) donor means that I will become infected with hepatitis.
3. I understand that I will receive medical treatment immediately after my transplant, including anti-viral therapy and on-going monitoring and testing.
4. I understand that the treatment for hepatitis C is very effective and more than 95% of patients with Hepatitis C infection can be successfully treated with 12 weeks of very safe and well tolerated medications.
5. I understand that the cost of the hepatitis C treatment will be covered by Pharmacare, however a deductible may need to be paid.
6. I understand there is a possibility that the initial treatment will not cure the infection and health complications may develop.
7. I understand that HCV can be transmitted to another person through blood interaction, and rarely through sex. At least one barrier method is required to prevent exchange of bodily secretions during sexual activity.
    a. Individuals who may become pregnant must review and agree to recommendations to prevent pregnancy during the first year post-transplant.
8. I understand that I can ask a transplant physician about any questions that I may have on receiving an organ from hepatitis C infected 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 a Hepatitis C NAT-positive 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