



6816

**Authorization for Surgery and/or Special Procedure/Treatment for
PEDIATRIC Kidney Recipient**

I, the individual signing below, am the parent or authorized legal representative of the minor child named below (my "Child") and hereby authorize **Drs. Hull, Brown, Lally, and Shames** to perform the following surgery and/or special procedure/treatment: **Kidney Transplant Recipient**, and if applicable I also authorize **Drs. Hull, Brown, Lally and Shames** to act as his/her assistant for the purpose of performing the following significant medical/surgical tasks as part of the surgery and/or special procedure/treatment: **Kidney Transplant Recipient** on _____.
(self or name of patient)

I understand that the Hospital is a graduate medical education-teaching site and that interns, residents and/or medical students may also be in attendance and/or assisting in the performance of the above specified surgery and/or special procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery and/or special procedure/treatment 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/procedure/treatment: (i) the nature and purpose of the proposed surgery/procedure/treatment; (ii) the reasonably foreseeable risks and consequences of the proposed surgery/procedure/treatment, including the risk that the proposed surgery/procedure/treatment may not achieve the desired objective; (iii) the alternatives to the proposed surgery/procedure/treatment and the reasonably foreseeable risks and benefits to such alternatives; (iv) the possible need for and the reasonably foreseeable risks of the transfusion of blood and blood products and (v) alternatives to the transfusion of blood and blood products and their reasonably foreseeable risks. Specifically in obtaining my informed consent to the surgery and/or special procedure, I have been informed of the following reasonably foreseeable risks: **anesthesia risks, pneumonia, donor organ failure or dysfunction with possible need for dialysis, wound infection, systemic infection, blood clot of leg or lung, bowel obstruction or perforation, heart attack, organ transplant technical complications of blood vessels or ureter needing repeat operation, bleeding, fluid collection and death.**

Patient Initials ()

I am aware that, in addition to the reasonably foreseeable risks described above, that there are other foreseeable risks, which have been discussed with me, but are not listed above. I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, 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/procedure/treatment, and that I may refuse transplantation on, my child, or the person whom I legally represent at any time without prejudice.

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 above-named physicians to do whatever may be necessary in the event any unforeseen conditions occur during the course of treatment and/or special procedure.

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 , images of my child or the person whom I legally represent, for medical, scientific or educational purposes, provided that 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.

This consent may be revoked by me at any time, except to the extent it has already been relied upon.



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Special Procedure/Treatment for PEDIATRIC Kidney Recipient

Signed: _____ Date: _____ Time: _____
(Patient or legally authorized representative)

Signature (MD, APRN, PA) 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: _____

PATIENT UNABLE TO SIGN [] BECAUSE:

M.D., PA, APRN Date: _____ Time: _____

Witness Date: _____ Time: _____