Patient information and consent to kidney transplantation from a living donor

Key messages for patients

- Please come to ward G5 at the time your living donor transplant coordinator has requested.

- Please bring with you any medications you use and its packaging (including patches, creams, inhalers, insulin and herbal remedies).

- **Transplantation is not without risk.** These risks are outlined in this document. By performing a kidney transplant your doctors have decided that the risks to your life from having a transplant are less than the risks of long-term dialysis.

- Please call the **living donor transplant co-ordinators** on **01223 596177** if you have any questions or concerns.

**Please read this information carefully.** You and your health professional will sign it to document your consent. After signing this consent form please give or send it to your living donor kidney transplant coordinator. This form must be signed before you can have a kidney transplant. After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know

Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent, up to the time the operation begins. If you do change your mind and no longer wish to have a transplant, it is important that you inform your doctor or transplant co-ordinator immediately.

A kidney transplant operation requires a general anaesthetic. You will have the opportunity to discuss this with the anaesthetist.

We will only carry out the procedure on your consent form unless, in the opinion of the responsible health professional, a further procedure is needed in order to save your life or prevent serious harm to you. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure, but the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998. We will also share information about you with NHS Blood and Transplant who are responsible for the administration of transplantation in the UK.
About living donor kidney transplantation

A kidney transplant operation has been recommended for you because either your own kidneys have already failed and you are on dialysis already, or your kidneys are failing and you will need to start dialysis soon.

The kidney will come from a living donor, who may or may not be known to you, but will have been assessed as suitable, according to agreed national guidelines for the assessment of living kidney donors.

Kidney transplantation is a major operation involving a surgical team working for about four hours. If successful, it will restore your kidney function and you will not need dialysis.

Kidney transplantation is the start of a different way of life. You will need regular follow up by the kidney specialists and you will need to take immunosuppression medicines for as long as the transplant lasts. These are explained in more detail in this document.

Intended benefits

Kidney transplantation offers you the possibility of either coming off dialysis or to avoid starting it. Most people who have had a kidney transplant consider they have a better quality of life and gain relief from (or avoid) several of the complications associated with dialysis.

We expect 98 out of 100 of our living donor kidney transplants to be working at least one year after the transplant operation, and 94 out of 100 to be working five years later. However if antibody removal treatment (desensitisation) is necessary because of an incompatibility between living donor and recipient of either blood group or tissue-type, these figures may be slightly lower. This will be discussed with you by your doctor.

Who will perform my procedure?

The kidney transplant operation will be carried out by an appropriately experienced and trained surgical team.

Before your procedure

Your nephrologist (kidney specialist) and transplant surgeon will have discussed your condition with you and with other surgeons and personnel related to the Transplant Programme. They will have agreed that a living donor kidney transplant is a suitable treatment for you.

Living donor kidney transplantation is a planned procedure, and you will be invited to attend the ward the week before (“pre-clerking”) to have some standard blood tests performed, including a crossmatch test, routine MRSA swabs, an ECG and a chest X-ray.
A doctor on the transplant ward will also check your medical history and examine you to make sure you are fit to have the operation. Occasionally pre-clerking results may identify an issue with either donor or recipient that requires further investigation, or in rare cases, a need to postpone the operation until it is safe to proceed.

You will be admitted to the transplant ward during the afternoon on the day before your operation. If you are on haemodialysis, this will be arranged at Addenbrooke’s for that evening. If you are on peritoneal dialysis you will need to continue your usual routine until the morning of your transplant. Your coordinator will discuss this with you.

**Hair removal before an operation**

If you have hair on your abdomen this will be removed before your operation by the healthcare team in the theatre suite using an electric hair clipper with a single-use disposable head. Please do not shave the hair yourself or use a razor to remove hair, as this can increase the risk of infection. Your healthcare team will be happy to discuss this with you.

It is usually necessary to shave other areas of your body during the procedure to allow equipment/machines, for example diathermy machines (used to seal blood vessels), to stick to your skin to achieve the best and safest result.

**During the procedure**

Before your procedure, you will be given a general anaesthetic - see below for details. We will place several fine tubes (cannulas/lines) into some blood vessels in your arms and neck. These give you fluids and/or blood and help us take blood for tests and monitor your condition. In addition, a tube may be passed into your stomach through your nose, to decompress (deflate) your stomach. We also place a urinary catheter into your bladder during the operation, to drain the urine, and this will stay in place for about five days.

The surgeons will make a long curved incision (cut) on one side of your lower abdomen. The donor kidney will then be connected up to the blood vessels that take blood to and from your legs and pelvic organs. We also connect the tube (the ureter) that takes urine from your kidney to your bladder so you can pass urine as normal. Typically, the operation takes four hours; if we encounter any difficulties or if you have had previous abdominal surgery or a previous kidney transplant, the operation might take substantially longer.

During surgery, you may lose blood. Depending on the amount of blood lost, your doctor may want to replace the loss with a blood transfusion, as significant blood loss can cause you harm.

Blood transfusion can involve giving you other blood components such as plasma and platelets which are necessary for blood clotting. Your doctor will only give you a
transfusion of blood or blood components during surgery, or recommend for you to have a transfusion after surgery, if you need it.

Compared to other everyday risks, the likelihood of getting a serious side effect from a transfusion of blood or blood component is very low. Your doctor can explain to you, the benefits and risks from a blood transfusion. Your doctor can also give you information about whether there are suitable alternatives to blood transfusion for your treatment. There is a patient information leaflet for blood transfusion available for you to read.

**We leave a small plastic tube called a stent across the join** between the urine tube from the kidney (the ureter) and the bladder. This will be removed a few weeks after the transplant, under local anaesthetic.

If you are on peritoneal dialysis, your dialysis catheter will be removed during the transplant operation.

A drain is also inserted into the abdomen to allow blood and fluid to drain from the transplant site. This is usually removed after about two days.

**After the procedure**

Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of the general anaesthetic have adequately worn off and you are conscious. They will monitor your heart rate, blood pressure and oxygen levels. You may be given oxygen via a facemask, intravenous fluids and appropriate pain relief until you are comfortable enough to return to the transplant ward. You may also have an ultrasound scan to check the blood supply to the new kidney.

Most patients will then go to the transplant ward (Ward G5). Patients with certain pre-existing health problems may be transferred to the intensive care unit (ICU/ITU) or transplant high dependency unit (HDU) on ward F5. These are areas where you will be monitored much more closely. If your surgeon or anaesthetist believe you should go to one of these areas after your operation, they will tell you and explain to you what you should expect.

**Eating and drinking.** Generally, you will be allowed to eat and drink on the first or second day after the operation.

**Getting about after the procedure.** We will encourage you to move around and carry out deep breathing exercises as soon as you are able to do so, usually the day after your transplant. This both reduces the chance of getting a blood clot in the leg and helps you to avoid chest infections.
Leaving hospital. Following a living donor kidney transplant, you are likely to need to stay in hospital for 6 to 10 days. In some circumstances you might need to stay longer, depending on your clinical condition and your doctor’s opinion.

Resuming normal activities including work. When you leave hospital, you should be able to carry out light daily activities at home. However, it might be a few months before you can return to normal active work.

Special measures after the procedure. Sometimes people feel sick after the operation and might vomit. If you feel sick, please tell a nurse and you will be offered medicines to make you more comfortable.

We will give you more detailed information about any special measures you need to take after the procedure. We will also give you information about things to watch out for that might be early signs of problems (for example, infection).

Check-ups and results: In the period after the operation, you will be seen in the transplant outpatient clinic at Addenbrooke’s very regularly (twice a week for the first four weeks) to check your progress and to make sure your kidney is functioning well. If your condition remains stable the time between clinic visits will increase to once weekly for the next month. Patients referred for kidney transplantation from hospitals other than Addenbrooke’s will usually return to their hospital after three months or when their condition is stable.

Significant, unavoidable or frequently occurring risks of this procedure

At the end of the first year after a kidney transplant around 98 out of 100 (98%) living donor kidney transplants will still be working; 2 in 100 (2%) will have failed. In addition 1 in 100 patients will have died in the first year following the transplant due to complications of the transplant operation or immunosuppression. To put this in perspective, there is also a significant risk of dying whilst on dialysis. The risk of dying on dialysis is higher in patients with diabetes and in older patients. For example, there is a 2 in 100 chance of dying each year on dialysis in patients aged 18 to 34, increasing to 15 in 100 in patients aged 65 to 74. Patients who face higher risks from the transplant operation will be asked to sign a separate consent form.

To help you understand what these mean visually we have printed below a drawing showing 100 people. 98 of the 100 are shaded black, representing the proportion of patients with a functioning kidney a year after the operation; 1 is white, representing the one death, and two are lightly shaded grey, representing the two patients who lost their transplants.
Thrombosis. There is a small risk (1 in 100) that the blood vessels of the new kidney will become blocked (thrombosis) following this procedure. This will lead to failure of the kidney and we will need to remove the new kidney in a further operation. You may then need to return to or start dialysis treatment.

Reoperations. There is a small chance (5 in 100) that you will need a second operation soon after the transplant to stop bleeding or remove blood clots or to correct leaking from the join with the bladder. Bleeding is slightly more common in patients who have had antibody removal.

Acute rejection. After the operation, the overall risk of acute rejection of the kidney transplant is 30 in 100. If this happens, we will need to give you some more powerful treatment which will usually reverse the situation, although rarely (1 or 2 in 100 cases) the kidney transplant may be lost from acute rejection. You may then need to return to or start dialysis treatment.

Continued dialysis after transplantation. Almost all living donor kidney transplants work straight away. However in rare cases there is a delay and you will need to continue dialysis until the kidney starts working. If you were on peritoneal dialysis before the transplant you will need to have haemodialysis until the kidney starts working because the peritoneal dialysis catheter is removed at the time of the transplant operation.

Admissions. Many people who have had a kidney transplant need to undergo further admissions into hospital in the subsequent months and years. These are necessary so that we can check the health both of yourself and your kidney transplant by using blood tests, scans, and biopsies.

Lymphocele. Around 15 in 100 patients develop a collection of fluid around the kidney in the first three months. This can press on the kidney and block the flow of urine to the bladder. If this occurs the fluid will need draining and may need a second
operation to drain the fluid. These are more common in patients who require
antibody removal – your doctor will explain this.

**Other complications.** As with any other operation, complications can occur, such as
wound infections, blood clot in the legs or on the lungs, fluid leakage from drains and
wound sites. These complications can often be managed with medication, rather than
any further surgical procedures. There is also a small risk of a heart attack
(myocardial infarction) as a consequence of the operation. To reduce the chances of
this you will have had several tests on your heart to check that it is sound enough to
get through the operation.

**Kidney transplants don’t last forever** and in time the transplant may fail. When
this happens you will need to go back onto dialysis. If you are fit enough you would
be placed back on the waiting list for another transplant. Around 60 to 70 in 100
living donor kidney transplants will work for at least 10 years.

**Recurrent disease.** Some diseases can recur in the transplanted kidney. If we think
there is a significant risk of this happening, your nephrologist will discuss this before
you are placed on the transplant list. The following is a list of some of the diseases
which can recur in the transplanted kidney along with the percentage of transplants
likely to fail from recurrent disease within 10 years after transplantation:

- mesangiocapillary glomerulonephritis type I (MCGN) 14%
- focal segmental glomerulosclerosis (FSGS) 13%
- membranous nephropathy 13%
- IgA nephropathy (“IgA”) 10%

**Alternative procedures that are available**

It is possible to live without a kidney transplant; depending on the condition of your
kidneys, you will need to continue with (or start) either haemodialysis or peritoneal
dialysis to perform some of the functions of healthy kidneys.

**Drugs**

You will need to take a number of medications on a long-term basis to
prevent rejection of the kidney transplant. This is called immunosuppression.
If you stop the immunosuppression medicines you will probably lose the
transplant.

In order to protect the kidney transplant from attack (rejection) by your immune
system, you need to take immunosuppressant medications. Some of these drugs are
used in combinations or for conditions for which they were not originally licensed. This
is common practice in transplant units such as ours, and the National Institute of
Health and Care Excellence have acknowledged such use. Any new drugs that we use
will have been approved by Addenbrooke’s Hospital Drug and Therapeutic Committee,
or, in the case of clinical trials, by a Research Ethics Committee.
Patient Information

Problems with immunosuppression

The powerful immunosuppressive medications which you need to take to protect your transplant organs can also reduce your immunity and make you more susceptible to some infections, particularly viral infections. In the first six months we will give you some antiviral drugs to minimise the risks of harmful viral infections. After six months the amount of immunosuppression you need is less, so the risk of infection is less.

The potential side effects of the immunosuppressive medicines include infections, kidney problems, diabetes, stomach upset and wound problems. It is sensible for all patients on the waiting list to be immunised against hepatitis B and, if you have never had chicken pox, to be immunised against this also. All women should have regular cervical smears.

The immunosuppressive medication increases your chances of developing cancer. Some cancers are much more common in transplant patients. Around 2 in 100 patients may develop a cancer of the lymph glands (lymphoma) which would need treatment and which can be fatal. Skin cancer is also very common, particularly if you have spent your life working outdoors. To reduce your chance of skin cancer you will be advised to wear a sun block cream whenever you are out in the sun and cover up where possible.

To reduce any side effects of immunosuppression and other drugs, the medical team will regularly monitor the medications you take and adjust them when required, based on your specific condition.

It is very important that you follow our instructions on when and how to take your medication. If you do not follow the dosage schedule strictly (i.e. if you miss taking tablets), you run a significant risk of losing your kidney. If we think you lost your kidney because you did not take the drugs as advised, it is unlikely that you would be offered a further transplant.

Please remember that the Transplant Unit has recommended the kidney transplant procedure to you because the doctors believe that the benefits will greatly outweigh the risks for you.

Information and support

If you have any anxieties or questions, please feel free to ask any member of the staff. Further information can be obtained from the living donor transplant co-ordinators who can be reached directly on 01223 596177 or 01223 256760 or through the Addenbrooke’s contact centre on 01223 245151; Information can also be obtained from the Addenbrooke’s website: www.cuh.org.uk
Anaesthesia

Anaesthesia means ‘loss of sensation’. For a kidney transplant you will have a general anaesthetic (see below).

Before your operation

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth; whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and may review your test results.

Pre-medications

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery. It also provides pain relief, reduces the risk of you being sick, or has effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

Moving to the operating room or theatre

Before starting your anaesthesia the medical team will perform a check of your name, personal details and confirm the operation you are expecting.

You will change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted and you may be asked to breathe oxygen through a face mask.

General anaesthesia

During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.
While you are unconscious and unaware, your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly assess your need for fluid or blood replacement.

**What will I feel like afterwards?**

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

When the effects of the anaesthesia wear off you may need pain relieving medication. If the team decide to keep you anaesthetised and on the breathing machine (ventilator) you will be looked after in the intensive care unit.

**What are the risks of general anaesthesia?**

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

**Very common (10 in 100 people) and common side effects (1 in 100 people)**

Feeling sick and vomiting after surgery
Sore throat
Dizziness, blurred vision
Headache
Bladder problems
Damage to lips or tongue (usually minor)
Itching
Aches, pains and backache
Pain during injection of drugs
Bruising and soreness
Confusion or memory loss
Chest infection

**Uncommon side effects and complications (1 in 100 to 1 in 1000 people)**

Heart attack or stroke
Muscle pains
Slow breathing (depressed respiration)
Damage to teeth
An existing medical condition getting worse
Awareness (becoming conscious during your operation)
Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications
Damage to the eyes
Serious allergy to drugs
Nerve damage
Equipment failure
Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK.

Information about important questions on the consent form

1 Creutzfeldt-Jakob Disease (‘CJD’)
We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2 Photography, audio or visual Recordings
As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3 Students in training
Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4 Use of tissue
As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.
If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.

**Privacy & Dignity**

We are committed to treating all patients with privacy and dignity in a safe, clean and comfortable environment. This means, with a few exceptions, we will care for you in same sex bays in wards with separate sanitary facilities for men and women.

In some areas, due to the nature of the equipment or specialist care involved, we may not be able to care for you in same sex bays. In these cases staff will always do their best to respect your privacy and dignity, eg with the use of curtains or, where possible, moving you next to a patient of the same sex. If you have any concerns, please speak to the ward sister or charge nurse.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site.
For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

**Other formats:**

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.info@addenbrookes.nhs.uk.

Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

**Document history**

Authors: Consultant transplant surgeon
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Living donor kidney transplantation

To replace the function of your diseased kidney with normal function from a living donor kidney.

We expect 98 out of 100 of our living donor kidney transplants to work at least one year after the transplant operation; we expect 60 or 70 out of 100 to be still working after 10 years.

1 in 100 chance of dying in the first year following the transplant operation;

1 in 100 risk that the blood vessels of the new kidney will become blocked following transplantation leading to failure of the kidney which will then need to be removed.

5 in 100 chance that you will require at least one further operation following the transplant.

30 in 100 risk of acute rejection of the kidney transplant requiring admission for treatment.

Some diseases may recur in the transplant causing it to fail sooner than it would have otherwise.

Wound infections, blood clot in the legs or on the lungs, fluid leak from drains and wound sites.

We take every effort to screen living kidney donors for infections and cancers, but we cannot guarantee that an infection or cancer will not be transmitted from the donor to you the recipient. The chances of this happening are small.

Most patients will require further admissions to hospital in the months/years after transplantation.

The intended benefits of the procedure (please state)

To replace the function of your diseased kidney with normal function from a living donor kidney.

We expect 98 out of 100 of our living donor kidney transplants to work at least one year after the transplant operation; we expect 60 or 70 out of 100 to be still working after 10 years.

b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

- 1 in 100 chance of dying in the first year following the transplant operation;
- 1 in 100 risk that the blood vessels of the new kidney will become blocked following transplantation leading to failure of the kidney which will then need to be removed.
- 5 in 100 chance that you will require at least one further operation following the transplant.
- 30 in 100 risk of acute rejection of the kidney transplant requiring admission for treatment.
- Some diseases may recur in the transplant causing it to fail sooner than it would have otherwise.
- Wound infections, blood clot in the legs or on the lungs, fluid leak from drains and wound sites.
- We take every effort to screen living kidney donors for infections and cancers, but we cannot guarantee that an infection or cancer will not be transmitted from the donor to you the recipient. The chances of this happening are small.
- Most patients will require further admissions to hospital in the months/years after transplantation.

What the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
Consent Form

Living donor kidney transplantation

d) any extra procedures that might become necessary during the procedure such as:

[ ] Blood transfusion   [ ] Other procedure (please state)

The following information leaflet has been provided:
Living donor kidney transplantation

Version, reference and date: CF492 version 1 April 2015

or [ ] I have offered the patient information about the procedure but this has been declined.

This procedure will involve:

[ ] General and/or regional anaesthesia   [ ] Local anaesthesia   [ ] Sedation   [ ] None

Signed (Health professional): ____________________________ Date: ______/_____/______

Name (PRINT): ____________________________ Time (24hr): ______/_____/______

Designation: ____________________________ Contact/bleep no: ____________________________

C  Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a tick in the relevant boxes for the following questions:

1  Creutzfeldt Jakob disease (CJD)
Have you ever been notified that you are at risk of CJD or variant CJD for public health purposes? If yes, please inform your health professional.

[ ] Yes   [ ] No

2  Photography, Audio or Visual Recording

a) I agree to the use of any of the above type of recordings for the purpose of diagnosis and treatment.

[ ] Yes   [ ] No

b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting.

[ ] Yes   [ ] No

3  Students in training
I agree to the involvement of medical and other students as part of their formal training.

[ ] Yes   [ ] No

Patient safety – at the heart of all we do

Addenbrooke’s Hospital | Rosie Hospital
4 Use of Tissue
a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .......................................................... Date: D.D./M.M./Y.Y.Y.Y.
Name of patient (PRINT): ..........................................................

If signing for a child or young person; delete if not applicable.
I confirm I am a person with parental responsibility for the patient named on this form.
Signed: .......................................................... Date: D.D./M.M./Y.Y.Y.Y.
Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.
Signed (Witness): .......................................................... Date: D.D./M.M./Y.Y.Y.Y.
Name of witness (PRINT): ..........................................................
Address:  

Addenbrooke's Hospital | Rosie Hospital
**Consent Form**

**Living donor kidney transplantation**

**D  Confirmation of consent**

**Confirmation of consent** (where the treatment/procedure has been discussed in advance)
On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Name (PRINT): .................................................................................. Job title: ..........................................................

Please initial to confirm all sections have been completed: ..........................................................

**E  Interpreter’s statement (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Name (PRINT): ..................................................................................

Or, please note the language line reference ID number: ..........................................................

**F  Withdrawal of patient consent**

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Signed (Health professional): .......................................................... Date: ...D.D./M.M./Y.Y.Y.Y...

Name (PRINT): .................................................................................. Job title: ..........................................................