I hereby give my consent and authorize: _______________________________ to perform a lung transplant.
(The list of possible assistants, all of whom are credentialed to provide surgical services at the hospital is available)

1. The care provider has explained my condition to me, the benefits of having the above treatment procedure, and alternate ways of treating my condition. I understand that no guarantees have been made to me about the result of the treatment or this transplanted organ.

2. The care provider has discussed with me the reasonably foreseeable risks of the treatment and that there may be undesirable results. The risks that are specifically related to this procedure include: respiratory failure, bleeding, infection, complications related to immunosuppression, delayed or poor function of the transplanted lung, the possibility that the transplanted lung will not function, or death.

I will receive a standard allocation organ: □ Yes □ No

I will receive an extended criteria donor organ: □ Yes □ No
If yes, I understand that this organ is considered an extended criteria organ for the following reason(s) _______________________________________________________

My surgeon has explained the risks and benefits of using an extended criteria donor organ and I consent to the implantation of this organ in my body.

3. I have carefully read and fully understand this Informed Consent form, and have had sufficient opportunity to discuss my condition and the above procedure(s) with the care provider and his/her associates, and all of my questions have been answered to my satisfaction.

Please tell us in your own words about the planned procedure. Do not sign this form unless you understand what your doctor has told you. You can ask questions at any time.

______________________________________________ __________________   ________________
Signature of Patient       Date   Time

____________________________________________  _____________________________________
Signature of Parent or Legal Guardian     Relationship to the Patient
(If Patient is unable to sign or is a minor)

If interpreter used, print name and company____________________________________________

ATTESTATION
I have fully explained the procedure, with associated risks, and alternatives, to the patient’s stated satisfaction. The patient expresses his/her desire to proceed with the plan as indicated above.

__________________________________           __________________________________
Signature of Care Provider                                            Title

__________________________________           __________________________________
Date                                                                                Time

Send to Medical Records for scanning into CarePlus