I _____, know that I am required to have a thorough medical and psychosocial evaluation before I can be considered to be a living donor. The evaluation will be conducted by the living donor team (living donor coordinators, social worker, transplant physician, surgeon, transplant psychologist, living donor advocate, and dietitian).

I have been informed of the following and understand:

- I, as the donor, have the right to opt out of the donation at any time during the process and that my decision will be protected and remain confidential.
- The hospital performing my donor surgery will take all reasonable precautions to provide confidentiality for the living donor and recipient.
- I acknowledge transplant laboratory personnel will verify histocompatibility as part of the organ donor process through cross-matching a sample of my blood with a sample of the intended recipient's blood. While all available measures will be taken to protect my privacy, I consent to use of my personal identifying information, specifically my donor name and Medical Record Number, in the laboratory reporting results for this match, which will be maintained in the intended recipient's health record.
- I have a living donor advocate available to talk with me before, during and after my procedure to ensure that all of my questions have been addressed.
- It is a federal crime for any person to knowingly acquire, obtain or otherwise transfer any human organ for anything of value including but not limited, to cash, property and vacations.
- If my recipient's transplant is not provided at a Medicare approved transplant center it could affect the recipient's ability to have their immunosuppressive drugs paid for under Medicare Part B.
- Any transplant candidate may have an increased likelihood of adverse outcomes (including but not limited to graft failure, complications, and mortality) that:
    - Exceed local or national averages
    - Do not necessarily prohibit transplantation
    - Are not disclosed to the living donor
- The possibility that future health problems related to my donation may not be covered by my insurance and that my ability to obtain health, disability or life insurance may be affected.
- The risks and possible complications to me as the donor and the alternative treatments available for the recipient.
- National and center specific transplant outcomes for recipients and donors.
- All communication between myself and the transplant staff will remain completely confidential and will not be shared with any other individuals.
- The evaluation and surgical processes including how long the procedure will take and what to expect in the days, week and months following my surgical procedure and what activities I may participate in and/or should refrain from.
- I understand transplant hospitals will determine who is a candidate for transplant and donation based on their hospital specific protocols and clinical judgment.
- I understand if I am not found to be a suitable candidate by The Ohio State University Wexner Medical Center team, I can be evaluated by a different transplant program that may have different selection criteria.
- The OSUWMC Transplant program is required to obtain from me a living donor blood specimen, at the time of surgery, and store the specimen for 10 years, only to be used for investigation of potential donor-derived disease.
- The potential medical and/or psychosocial risks to me as the donor during evaluation include but are not limited to:
    - Allergic reactions to contrast
    - Discovery of reportable infections
    - Discovery of serious medical conditions
    - The risk of preeclampsia or gestational hypertension is increased in pregnancies after donation
    - Discovery of adverse genetic findings unknown to me and discovery of certain abnormalities that will require more testing at my own expense or create the need for unexpected decisions by the transplant team
    - Living kidney donors may have a higher risk of developing ESRD than healthy non-donors with similar medical characteristics

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INFORMED CONSENT FOR LIVING DONOR EVALUATION

Patient Name:

Medical Record Number:

Date of Birth:

- Potential psychosocial risks:

*Depression * Problems with body image * Regret *Mood fluctuation

*Anxiety *Feeling overwhelmed * Guilty *Fatigue

*Hopelessness *Irritability *Difficulty sleeping

*Post-traumatic stress disorder (PTSD)

*Impact donation may have on my lifestyle

*Feelings of emotional distress or bereavement if the transplant recipient experiences organ failure or death

I understand that the OSUWMC program is required to provide follow up information about me and how I am doing at 6, 12 and 24 months and I commit to follow up testing coordinated by OSUWMC living donor staff.

I also understand that a deceased donor organ may become available before my evaluation is complete or before the living donor transplant occurs.

As part of my living donor patient education, it has been explained to me and I understand there are short and long-term medical and psychosocial risks to both me as the living donor and to the recipient associated with my donation.

I agree to have my information from this evaluation shared with the transplant team members involved in my care. I understand that health information obtained during the living donor evaluation is subject to the same regulations as all medical records and could reveal conditions that the transplant center must report to local, state or federal public health authorities.

I have read this consent form or have had it read to me. I have had a chance to ask questions about this form and the evaluation process. My questions have been answered to my satisfaction and I understand the consent that I am giving. I am signing this form as my consent.

Donor Signature:_____ Date/Time: _____

Witness Signature: _____ Date/Time: _____

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INFORMED CONSENT FOR LIVING DONOR EVALUATION

MC202505 (6/21)

CONSENT

Patient Name:

Medical Record Number:

Date of Birth: