Queen Elizabeth Hospital Birmingham NHS
Part of University Hospitals Birmingham
NHS Foundation Trust

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name .....
Patient's first name(s) .....
Date of birth .....
Responsible health professional .....
Job title .....
NHS number (or other identifier) .....

[redacted]

GP: EARDLEY

☐ Male ☐ Female

Special requirements .....
(eg other language / other communication method)

To be retained in patient's notes

Form A

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) _____

Liver transplant (BBD / DCD / Split)

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits To prolong survival.

Significant, unavoidable or frequently occurring risks Bleeding/Infection/DVT/PE/Vascular complications/Biliary complications/Non-function/Rejection/Immunosuppression/Diabetes/Renal failure/Retransplant/Recurrence

Any extra procedures which may become necessary during the procedure (please note if not applicable)

☑ Blood transfusion _____

☐ Other procedure (please specify) _____

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided: _____

This procedure will involve:

General and/or regional anaesthesia ☑ Local anaesthesia ☐ Sedation ☐ No anaesthesia ☐

Signed _____ Date 13/3/18

Name (PRINT) [redacted] Job title Senior Fellow

Contact details (if patient wishes to discuss options later) **Extension number:** _____

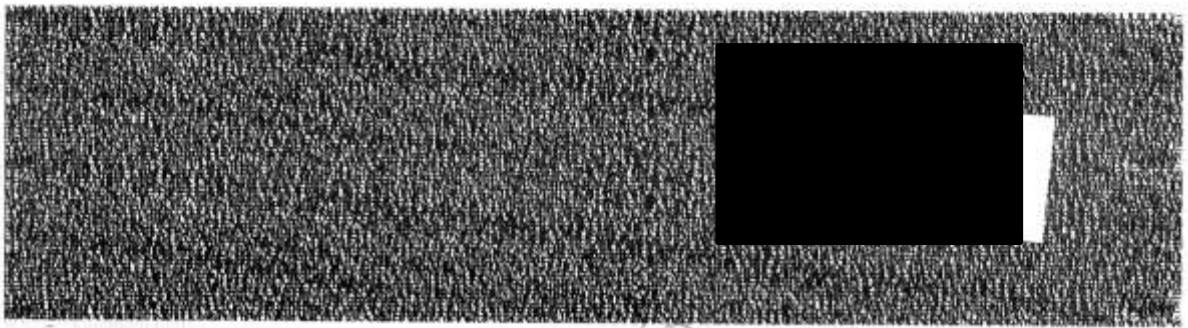
Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed _____ Date _____

Name (PRINT) _____

Patient identifier label



Top copy accepted by patient: yes / no (please circle)

Statement of patient

Please read this form carefully, you should be offered a copy of the page which describes the benefits and risks of the proposed treatment. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form. Please read the section below and complete any section where a response is required.

Patient agreement

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand there may be supervised trainee health care professionals involved in my treatment or procedure.

I understand that any photographic images which are produced as part of my normal treatment, may at some time be used for diagnosis, further treatment, research, teaching or study; however I will be informed and my identity removed. I understand that if imaging, such as x-rays and scans is used for research, teaching or study purposes, they will be fully anonymised.

I understand that additional procedures may become necessary during my treatment. **I understand** that any procedure in addition to those described on this form may be carried out if it is necessary to save my life or to prevent serious harm to my health. I have listed below any procedures **which I do not wish to be carried out even to save my life** without further discussion:

Patient's signature [redacted] Date 13.6.18

Name (PRINT) _____

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/ children may also like a parent to sign here (see notes).

Signed _____ Date _____

Name (PRINT) _____

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Patient identifier/label

[redacted] MALE 4913

Important notes: (tick if applicable)

Patient has withdrawn consent (ask patient to sign/date here) ☐

See also advance decision/living will (e.g. Jehovah's Witness form) ☐

Agreement to tissue donation for research

I consent to the storage and use of any tissues (may include blood and body fluids) removed during the course of my treatment, for ethically approved research projects in the future, including genetic studies and medical research which may use animals. I understand that the use of my tissues may be linked to my health records and that full attention to data confidentiality will be maintained. Any medical information about me, or any research data generated from the use of my samples, will be stored in an anonymous way that protects my identity.

I understand that my tissues may be used by researchers outside of Birmingham and that I will not gain financially from any drugs or treatments resulting from any research for which tissue is used.

Signed [redacted]

Queen Elizabeth Hospital Birmingham NHS
Part of University Hospitals Birmingham
NHS Foundation Trust

Patient agreement to investigation or treatment

Patient details (or pre-printed label)

Patient's surname/family name .....
Patient's first name(s) .....
Date of birth .....
Responsible health professional .....
Job title .....
NHS number (or other identifier .....

[redacted]

P: ADAMS

☐ Male ☐ Female

Special requirements .....
(eg other language / other communication method)

To be retained in patient's notes

Form A

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear) liver transplantation DBD vs. DCD; whole vs. split; + umbilical hernia repair.

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits to improve benefits / survival.

Significant, unavoidable or frequently occurring risks bleeding, DVT or PE, infections; PNF; HAT, PVT; DGF, AKI; CKD; ACR; chronic rejection; re-transplantation; re-laparotomy, bile leak, bowel leak, immunosuppression (DM, cancer, infections), recurrence, mortality

Any extra procedures which may become necessary during the procedure (please note if not applicable)

☐ Blood transfusion

☐ Other procedure (please specify)

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

The following leaflet/tape has been provided:

This procedure will involve:

General and/or regional anaesthesia ☒ Local anaesthesia ☐ Sedation ☐ No anaesthesia ☐

Signed [redacted] Date

Name (PRINT) Amanda Caplan Job title

Contact details (if patient wishes to discuss options later) **Extension number:**

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed Date

Name (PRINT)

Patient identifier label

[redacted]

Top copy accepted by patient: yes / no (please circle)

Statement of patient

Please read this form carefully, you should be offered a copy of the page which describes the benefits and risks of the proposed treatment. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form. Please read the section below and complete any section where a response is required.

Patient agreement

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I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

I understand there may be supervised trainee health care professionals involved in my treatment or procedure.

I understand that any photographic images which are produced as part of my normal treatment, may at some time be used for diagnosis, further treatment, research, teaching or study; however I will be informed and my identity removed. I understand that if imaging, such as x-rays and scans is used for research, teaching or study purposes, they will be fully anonymised.

I understand that additional procedures may become necessary during my treatment. **I understand** that any procedure in addition to those described on this form may be carried out if it is necessary to save my life or to prevent serious harm to my health. I have listed below any procedures **which I do not wish to be carried out even to save my life** without further discussion:

_____

_____

Patient's signature [redacted] Date 7-2-2015.

Name (PRINT) [redacted]

A witness should sign below if the patient is unable to sign but has indicated his or her consent. Young people/ children may also like a parent to sign here (see notes).

Signed _____ Date _____

Name (PRINT) _____

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signed _____ Date _____

Name (PRINT) _____ Job title _____

Patient identifier/lab [redacted]

Important notes: (tick if applicable)

Patient has withdrawn consent (ask patient to sign/date here) ☐

See also advance decision/living will (e.g. Jehovah's Witness form) ☐

Agreement to tissu

I consent to the storage and use of any tissues (may include blood and body fluids) removed during the course of my treatment, for ethically approved research projects in the future, including genetic studies and medical research which may use animals. I understand that the use of my tissues may be linked to my health records and that full attention to data confidentiality will be maintained. Any medical information about me, or any research data generated from the use of my samples, will be stored in an anonymous way that protects my identity.

I understand that my tissues may be used by researchers outside of Birmingham and that I will not gain financially from any drugs or treatments resulting from any research for which tissue is used.

Signed [redacted]