Transplant Evaluation Consent Packet

Patient Name:

Date of Birth:

☐Personal Data Sheet (pages 1-3)

☐Informed Consent for Evaluation (page 4)

☐Authorization for Release of Protected or Privileged Health Information (page 5-6)

☐Consent to Research (page 7)

☐Informed Consent for Acceptance of Kidneys with a KDPI Greater than 85% (page 8)

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MASSACHUSETTS GENERAL HOSPITAL
TRANSPLANT CENTER

Kidney Transplant Personal Data Sheet

Your Name: _____

Date of Birth: _____

Your nephrologist's name: _____

Your Address/Contact Information

Please call Mass General Registration at (781) 960-1201 or 866-211-6588 to update or confirm your address, social security number, telephone numbers, primary care physician name, emergency contact name and telephone.

- **If we don't have your social security number, we cannot place you on the kidney transplant waitlist**.
- **If your contact information is not up to date, you may miss out on a kidney transplant.**

Confirmation: ☐ I have called Mass General Registration and updated all the contact information listed above.

Personal Information

Marital Status (*please circle one*) Single Married Divorced/Separated Widowed

Number of Children (*if any)*: _____

Who do you live with? (*please circle one*) Alone Family Friends Others

Were you born in USA? (*please circle one*) Yes No
If ***not*** born in US, where were you born? _____ Year you came to USA?_____

Are you a U.S. citizen? (*please circle one*) Yes No
If ***not***, are you U.S. Resident? Yes No

Do you work for income? (*please circle one*) Yes No
If you work, what is your occupation? _____

Highest Level of Education attained: _____

Personal Habits

Do you smoke or use tobacco? (*please circle one*) Yes In the past only Never

If yes, for how many years have you used tobacco? _____ years
If you quit tobacco, what year did you quit ? _____ year
If you currently smoke or have smoked in the past, how much do you smoke?
Cigarettes _____(packs per day) Cigars _____(#/day) Pipe _____ (#/day)

Do you drink alcohol? (*please circle one*) Yes In the past only Never

If *yes,* how much do you drink?

Beer _____(cans per week)
Wine _____(glasses per week)
Liquor _____(cocktails per week)

Do you use marijuana? (*please circle one*) Yes In the past only Never

If *yes*, how much? _____
If *yes*, how often? _____ (uses/week)
If *yes*, for how many years have you used? _____ (years)
Do you have a medical marijuana card? Yes No

Do you use other drugs? (*please circle one*) Yes In the past only Never

If yes, for how many years have you used drugs? _____ (years you used)
If you quit drugs, what year did you quit? _____ (year you quit)
When you use or used drugs, how often? _____ (uses/week)

(When answering the questions above, include intravenous, smoked, or oral intake, including heroin, cocaine, amphetamines, K2/spice, ecstasy, bath salts, oxycontin, oxycodone, and other opiates, benzodiazepines, and any similar substances not prescribed by a physician).

Brief Health History

Have you ever had cancer, including any form of skin cancer? (*circle one*) Yes No
Have you ever needed a heart stent or bypass surgery? (*circle one*) Yes No
Have you ever been told you had diabetes or high blood sugar? (*circle one*) Yes No
If *yes*, how old were you when you were told you have diabetes? _____
Do you have trouble with blood flow to your legs? (*circle one*) Yes No
Have you ever had an open ulcer or sore on your foot? (*circle one*) Yes No
Have you ever had a blood clot in your legs or lungs? (*circle one*) Yes No

Mental Health History

Have you been diagnosed with depression, anxiety, bipolar, PTSD, OCD, or other psychiatric disorder? (*circle one*) Yes No
If *yes*, have you been hospitalized for psychiatric reasons? Yes No
Have you been prescribed medications for psychiatric reasons? Yes No
Have you ever seen a therapist? Yes No
If *yes*, please provide the name of the therapist: _____

Exercise, Walking and Functional Status

Have you ever needed a cane? (*please circle*) Yes No
Have you ever needed a walker? (*please circle*) Yes No
Have you ever needed a wheel chair? (*please circle*) Yes No
Do you exercise? (*please circle*) Yes No
If *yes,* how often and what exercise? _____

Living Wills & Advanced Directives

Do you have a "Do Not Resuscitate" (DNR) order? (*please circle*) Yes No
Do you have a living will? (*please circle*) Yes No
Do you have a health care proxy (power of attorney)? (*please circle*) Yes No

Current Health Status – please **circle** the **number** that best represents your current health:

100%	Normal, no complaints; no evidence of disease.
90%	Able to carry on normal activity; minor signs or symptoms of disease.
80%	Normal activity with effort; some signs or symptoms of disease.
70%	Cares for self; unable to carry on normal activity or to do active work.
60%	Require occasional assistance, but able to care for most of personal needs.
50%	Requires considerable assistance and frequent medical care.
40%	Disabled; require special care and assistance.
30%	Severely disabled; hospital admission may be indicated
20%	Very sick; hospital admission necessary.

Medications and Allergies

- *Please bring a list of your medications and your allergies, or enter them below*
- *If your primary physician or kidney doctor works at Mass General, Brigham & Women's, North Shore Medical Center or another Partners Healthcare Facility, you do not need to complete the medication and allergy sections.*

Medication Name	Dosage	How many times per day?

Allergies	What reaction do you experience?

MASSACHUSETTS GENERAL HOSPITAL

TRANSPLANT CENTER

2Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

INFORMED CONSENT FOR EVALUATION AS A POTENTIAL TRANSPLANT RECIPIENT

In preparation for an evaluation as a potential candidate for transplant, I have been provided a copy of the *Information for Evaluation*, the MGH *Patient Bill of Rights and Responsibilities*, the United Network for Organ Sharing's (UNOS) *Questions and Answers for Transplant Candidates about Multiple Listing and Waiting Time Transfer* and the physician and transplant nurse have discussed the following with me:

- The evaluation process, including selection criteria.
- The surgical procedure, including post-operative treatment.
- Availability of alternative treatments.
- Potential medical and psychosocial risks.
- Current national and Massachusetts General Hospital Transplant Center specific outcomes for recipients of and living donors for the organ for which I am being evaluated released 1/2021.
- Donor risk factors affecting outcomes. If I accept an organ from a deceased donor with risk criteria. I have been informed that I have the right to receive post-transplant infectious disease testing.
- Notification about any Medicare outcome requirements not being met by the Transplant Center.
- My right to refuse transplant.
- Financial responsibilities related to transplant.
- Immunosuppressive drug payments.
- Information on my ability to be on the waiting list at more than one transplant center.
- My option to transfer my care to another transplant center without losing accumulated time on the waiting list.
- If Massachusetts General Hospital is not a Medicare-approved transplant center for the organ which I am to receive it could affect my ability to have immunosuppressive drugs paid for under Medicare Part B.

Should I get listed for an organ I authorize the release of minimum necessary protected health information to UNOS including but not limited to my: name, address, social security number, sex, race, residency status, height/weight and blood typing.

All of my questions have been answered and I give my consent to proceed with the evaluation and wait listing, if deemed a candidate.

I, _____, certify by my signature below that I would like to proceed with the evaluation to determine transplant candidacy.

Potential Recipient (or Parent/Guardian) Signature: _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

By my signature, I affirm I reviewed the above information with the patient; the patient verbalized understanding and was provided an opportunity to ask any questions.

PARTNERS HEALTHCARE

MASSACHUSETTS GENERAL HOSPITAL

PRINT SAVE AS RESET

MGH Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Phone: 617 726 2361
FAX: 617 726 3661

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

For copies of radiology images or films, contact 617 726 1798 / Fax 617-724-0264

http://www.massgeneral.org/imaging/about/order_images_films.aspx

A. PATIENT INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

PATIENT MEDICAL RECORD # _____

PATIENT ADDRESS: **STREET:** _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE CONTACT #: **DAY: ( )** _____ **EVENING: ( )** _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information.

From:

Name: _____

Address: _____

_____

Telephone Number: _____

Send by:

☐ Mail

☐ Electronically (secure email)

Email Address: _____

To:

Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

Purpose (check the appropriate box)

☐ Medical Care
☐ Insurance*
☐ Legal Matter*
☐ Personal*
☐ School
☐ Other (please specify)* _____

* Copying fees may apply

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

☐ Medical Record Abstract/dates _____
(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)

☐ Clinic Visit Notes/dates _____

☐ Discharge Summary/dates _____

☐ Lab Reports/dates _____

☐ Operative Reports/dates _____

☐ Pathology Reports/dates _____

☐ Radiation Reports/dates _____

☐ Radiology Reports/dates _____

☐ Photographs/dates (costs may apply) _____

☐ Billing Records/dates _____

☐ Other *(please specify below and include dates)* _____

_____

_____

_____

_____

See Page 2 on Reverse

PARTNERS HEALTHCARE

MGH 1811 MASSACHUSETTS GENERAL HOSPITAL

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

D. Please check YES to indicate if you give permission to release the following information if present in your record:

☐ Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES _____

☐ Yes **Genetic Screening test results (SPECIFY TYPE OF TEST)** _____

☐ Yes **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

☐ Yes **Other(s):** Please List _____

☐ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that my permission may not be required to release my mental health records for payment purposes)*

☐ Yes Confidential Communications with a Licensed Social Worker

☐ Yes Details of Domestic Violence Victims' Counseling

☐ Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - if PHS has already relied upon it (for example, once information is released, it will not be retrieved)
  - if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date _____

Clinic/Office: _____

Pick-up Identification:

_____ License _____ State ID _____ Passport _____ Other Photo ID _____

MASSACHUSETTS GENERAL HOSPITAL

HARVARD MEDICAL SCHOOL

TRANSPLANT CENTER

MGH Kidney, Liver, Pancreas Transplant Program
165 Cambridge Street, Suite 301
Boston, MA 02114
Tel: 877-644-2860
Fax: 617-643-4261

James F. Markmann, MD, PhD
Chief, Division of Transplantation
Massachusetts General Hospital
Surgical Director, Liver, Pancreas, Islet Transplant Programs
Clinical Director, MGH Transplant Center

Dear Transplant Candidate:

Transplantation is life saving for patients with severe organ failure. Although it is a highly successful therapy we can make it even better by finding ways to transplant more patients and by finding ways to transplant successfully without lifelong medicines to prevent rejection. The Massachusetts General Hospital Transplant Center is a leader in cutting-edge clinical trials exploring new immunosuppression, tolerance induction, islet cell transplantation and ways to make more organs transplantable. We are committed to informing as many patients as we can about our research studies.

As part of your transplant evaluation, we would like to give you the option to hear about our studies. Answering the question below will allow our research staff members to contact patients interested in research. Taking part in a study is voluntary, whether you participate or not will not affect on the care you receive.

Patients who agree to be contacted may receive a phone call from a research staff member if we feel there are research opportunities that may be of interest to you.

If you have any questions, feel free to ask your doctor or transplant coordinator.

Sincerely,

James Markmann, M.D. Ph.D.

☐ Yes, I am willing to be contacted about transplant related research studies.

☐ No, I prefer not to be contacted about transplant related research studies.

Print Name _____

Place Patient Label Here

MASSACHUSETTS GENERAL HOSPITAL

TRANSPLANT CENTER

PATIENT IDENTIFICATION AREA

INFORMED CONSENT FOR ACCEPTANCE OF KIDNEYS WITH A KDPI GREATER THAN 85%

In preparation for consenting to a kidney donor with a kidney donor profile index (KDPI) greater than 85%, I have been provided a copy of the UNOS "Questions and Answers for Transplant Candidates about Kidney Allocation" and the physician and transplant nurse have discussed the following with me:

- The kidney matching system
- How kidneys will be classified (KDPI score from 0-100%) based on the donor's age, height, weight, ethnicity, history of stroke, high blood pressure, diabetes, hepatitis C, how the donor died (loss of heart function or brain function) and serum creatinine level
- The risks and benefits of receiving a donor kidney with a KDPI greater than 85%
- That a donor kidney with a KDPI greater than 85% is likely to function for a shorter time than a kidney with a lower KDPI
- That my participation in this program is voluntary and that I may choose not to accept a donor kidney with a KDPI greater than 85% at any time

I, _____ , certify by my signature below that I would like to proceed with accepting a donor kidney with a KDPI greater than 85%.

Patient Signature: _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

By my signature, I affirm I reviewed the above information with the patient; the patient verbalized understanding and was provided an opportunity to ask any questions.

MASSACHUSETTS HEALTH CARE PROXY

Information, Instructions, and Form

What does the Health Care Proxy Law allow?

The **Health Care Proxy** is a simple legal document that allows you to name someone you know and trust to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (known as the "Principal") can appoint any adult EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption. Whether or not you live in Massachusetts, you can use this form if you receive your health care in Massachusetts.

What can my Agent do?

Your Agent will make decisions about your health care *only* when you are, for some reason, unable to do that yourself. This means that your Agent can act for you if you are temporarily unconscious, in a coma, or have some other condition in which you cannot make or communicate health care decisions. Your Agent cannot act for you until your doctor determines, in writing, that you lack the ability to make health care decisions. Your doctor will tell you of this if there is any sign that you would understand it.

Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your doctor or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

How do I fill out the form?

1 At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (**Optional:** If you think your Agent might not be available at any future time, you may name a second person as an Alternate Agent. Your Alternate Agent will be called if your Agent is unwilling or unable to serve.)

2 Setting limits on your Agent's authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. However, if you want to limit the kinds of decisions you would want your Agent or Alternate Agent to make for you, include them in the blank.

3 **BEFORE** you sign, be sure you have two adults present who will be witnesses and watch you sign the document. The only people who cannot serve as witnesses are your Agent and Alternate Agent. Then sign and date the document yourself. (Or, if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.)

4 Have your witnesses fill in the date, sign their names and print their names and addresses.

5 **OPTIONAL:** On the back of the form are statements to be signed by your Agent and any Alternate Agent. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?

After you have filled in the form, remove this information page and make at least four photocopies of the form. Keep the original yourself where it can be found easily (*not* in your safe deposit box). Give copies to your doctor and/or health plan to put into your medical record. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decisionmaking.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happens:

1. You sign another Health Care Proxy later on.
2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.
3. You notify your Agent, your doctor, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.
4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

AFTER FILLING IN THE FORM, REMOVE THIS INSTRUCTION PAGE. BE SURE TO TALK WITH YOUR AGENT.

YOUR BIRTH DATE (m/d/y)
____/____/____

MASSACHUSETTS HEALTH CARE PROXY

1 I, _____, residing at
(Principal: PRINT your name)

_____
(Street) (City/town) (State/ZIP)

appoint as my **Health Care Agent**: _____
(Name of person you choose as Agent)

of_____
(Street) (City/town) (State/ZIP)

Agent's tel (h) _____ (w) _____ E-mail _____

OPTIONAL: If my agent is unwilling or unable to serve, then I appoint as my **Alternate Agent**:

_____
(Name of person you choose as Alternate Agent)

of_____
(Street) (City/town) (State/ZIP) (Phone)

2 My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, *if any*, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3 **Signed**:_____ **Date:** ___/___/___ (mo/day/yr)

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____ _____
(Name) (Street)

_____
(City/town) (State/ZIP)

4 **WITNESS STATEMENT:** We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document.
In our presence, on this day ____/____/____ (mo / day / yr).

Witness #1 _____ Witness #2 _____
(Signature) (Signature)

Name (print) _____ Name (print) _____

Address _____ Address _____

_____ _____

5

Statements of Health Care Agent and Alternate Agent (OPTIONAL)

Health Care Agent: I have been named by the Principal as the Principal's **Health Care Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Health Care Agent**)_____

Alternate Agent: I have been named by the Principal as the Principal's **Alternate Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. But if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Alternate Agent**)_____

* * * * *

Health Care Proxy developed by Massachusetts Health Decisions in association with the following member organizations of the Massachusetts Health Care Proxy Task Force:

Boston University Schools of Medicine and Public Health:
Law, Medicine, and Ethics Program
Deaconess ElderCare Program
Hospice Federation of Massachusetts
Massachusetts Bar Association
Massachusetts Department of Public Health
Massachusetts Executive Office of Elder Affairs
Massachusetts Federation of Nursing Homes
Massachusetts Health Decisions
Massachusetts Hospital Association
Massachusetts Medical Society
Massachusetts Nurses Association
Medical Center of Central Massachusetts
Suffolk University Law School:
Elder Law Clinic
University of Massachusetts at Boston:
The Gerontology Institute
Visiting Nurse Associations of Massachusetts

For prices and information on quantity orders, or for non-English language licensing, please contact non-profit

Massachusetts Health Decisions

Email: proxy@masshealthdecisions.org

rev. 1/15

MASSACHUSETTS GENERAL HOSPITAL
TRANSPLANT CENTER

165 Cambridge Street, Suite 301
Boston, MA 02114
Pre-Transplant: 877-644-2860/617-726-6631
Fax: 617-726-0822
www.massgeneral.org/transplant

Kidney Transplant Candidate Education

Kidney transplantation is most successful when the transplant recipient has a complete understanding of the risks and benefits. Kidney transplant candidates are required to receive education about transplant evaluation and transplantation prior to listing with the United Network for Organ Sharing (UNOS). Candidates can receive the required education by attending a class in person at Mass General or by viewing Mass General's recipient education video series at the following internet address:

https://tinyurl.com/MGHKidneyRecipientEducation

Confirmation of Kidney Transplant Candidate Education

I acknowledge that I have received education regarding kidney transplant evaluation and the risks and benefits of kidney transplantation, as follows:

1. I have received and read the document "Massachusetts General Hospital Information for Evaluation as a Kidney Transplant Recipient."

2. I have viewed the "Massachusetts General Hospital (MGH) Kidney Transplant Recipient Education Class (Run time 54 minutes)" presentation, available at:

   https://tinyurl.com/MGHKidneyRecipientEducation

I further acknowledge that I have had my questions about kidney transplant evaluation and kidney transplantation answered in discussion with a transplant nurse coordinator.

Date: _____

Transplant Candidate Name: _____ (*print*)

Transplant Candidate Signature: _____