UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DECLARATION OF URGENT MEDICAL NEED
CONSENT FROM *DONOR*

Donor Name (Last, First Middle):	**Donor MRN:**

Ineligible Donor for the Following Reason(s):

☐ ***INELIGIBLE***

Donor is considered ineligible for the following reason(s):

INFECTIOUS DISEASE TESTING

- ☐ Some or all of the infectious disease testing results were reactive or positive*
- ☐ Some or all of the infectious disease testing results are not current (outside of required time-frame)*
- ☐ Some or all of the infectious disease testing has not been performed or completed*
- ☐ Some or all of the testing was not performed in a CLIA certified lab and/or FDA approved testing was not used*

DONOR SCREENING / PHYSICAL ASSESSMENT

- ☐ Donor screening, medical records or physical assessment indicates clinical evidence of, or the presence of, risk factors for communicable or transmissible diseases*
- ☐ Donor screening is not current (outside of required time-frame)*
- ☐ Donor screening has not been completed*

***Additional Information:** _____

_____

_____

_____

_____

Rationale for Urgent Medical Need Use

Donor screening and/or testing results suggests that you may be at risk for transmission of a communicable disease to the recipient which places you into **ineligible donor** category.

Due to the possible increased risk of disease transmission associated with transplanting products from an ineligible donor, **Urgent Medical Need** must be documented prior to proceeding with the collection.

Urgent Medical Need indicates that the potential risk of disease transmission is outweighed by the benefits associated with providing the recipient your cells as there is currently no comparable product and the recipient is at higher risk for other complications and even death if the cells are not collected and released for the intended use.

The physician has considered all of the information discussed with you and has deemed it appropriate to proceed with collection, if you agree to do so.

Additionally, the recipient must also be made aware of the risk and benefits of receiving your cells and the information that placed you in the ineligible donor category must be disclosed.

After discussion with the physician and reading the above information, I, the donor, choose to:

☐ ***Proceed / donate my cells to the recipient*** ☐ ***Decline to proceed / not donate***

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PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	DATE	TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT DUE TO PATIENT'S INCAPACITY, CHECK RELATIONSHIP TO THE PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 7. Other Blood Relative
☐ 2. Guardian ☐ 5. Parent ☐ 8. Other* _____
☐ 3. Husband/Wife ☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement

*** Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.**

PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	DATE	TIME

SIGNATURE OF WITNESS (OPTIONAL) **REQUIRED FOR TELEPHONE CONSENTS**	PRINTED NAME	DATE	TIME

INTERPRETER ATTESTATION:

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	DATE	TIME