DukeMedicine
Division of Cellular Therapy

ADULT AND PEDIATRIC BLOOD AND MARROW TRANSPLANT PROGRAM

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Request and Authorization Form for the Donation and/or Infusion of Emergency Cellular Products FRM1

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M04L
Rev. 12/18

DukeHealth

Request and Authorization Form for the Donation and/or Infusion of Emergency Cellular Products

Place Patient Label Here

1. I request and authorize Dr._____(Attending Physician) and/or his/her associates to perform the following procedure(s) on: _____
(name of patient)

   Description of procedure(s): □ **Donation of an Emergency Cellular Product**
   □ **Infusion of an Emergency Cellular Product**

2. I further request the administration of such anesthetics as my surgeon/proceduralist believe are necessary. I understand that anesthesia carries risks separate from the risks of the operation(s) and/or procedure(s).
3. I further consent to the administration of such drugs, infusions, injections or other treatments, tests or diagnostic procedures deemed necessary in the judgment of the attending physician during the performance of the above procedure(s).
4. I further consent to administration of plasma and/or blood transfusions deemed necessary in the judgment of the attending physician(s). The possible need for, risks of, and alternatives to blood transfusion have been explained to me, including possible risks of non-treatment.
   □ I request specific limitations on receipt of blood products. See Refusal of Blood and/or Blood Products form.
5. It has been explained to me that during the course of the operation(s) and/or procedure(s), unforeseen conditions may necessitate additional or different operation(s) and/or procedure(s)] than those described above. I therefore further authorize and request that the above-named physician, his/her assistants, or his/her designees perform such operation(s) and/or procedure(s) as are, in his/her professional judgment, necessary and desirable, including, but not limited to, procedures involving surgery.
6. I agree that any tissues, organs, and body fluids removed during the course of the operation(s) and/or procedure(s) may be examined, documented, preserved and/or disposed of in a manner considered proper for purposes of diagnosis, study and advancement of medical knowledge, with any appropriate protection of patient identity.
7. The attending physician or his/her designee has provided sufficient information to give me a general understanding of the nature and purpose of the operation(s) and/or procedure(s), the benefits thereof and the usual, most frequent and most serious risks and hazards involved. Alternative methods of treatment and the risks and benefits of these alternatives, including possible results of non-treatment, the likelihood of achieving the goals/desired results, and any potential problems that might occur during recuperation have also been explained to me.
8. I recognize that the results from the practice of medicine and surgery are not absolutely predictable, and I acknowledge that no guarantees or assurances have or can be made concerning the results of such operation(s) and/or procedure(s).
9. I understand that the Duke University Health System (DUHS) sites are teaching facilities, and I agree that students training to be physicians, nurses and allied health personnel may assist and participate in providing my care and that my medical records may be used for purposes of research, education and patient care. Also, I understand and agree that vendor representatives may be present at times during my care and treatment at DUHS and may participate in my care as my health care providers deem appropriate.
10. I have been informed that graduate medical trainees (residents and fellows) and qualified non-physician practitioners (specifically including physician assistants and nurse practitioners) may be involved in my surgical procedure pre-operatively, intra-operatively, and post-operatively.
11. I also have been informed that (1) my attending physician will be physically present during the key and critical portions of my procedure; and (2) during other portions of my procedure, he/she may be involved in another procedure which is expected to overlap in part with my procedure. I have been informed that if my attending physician is not physically present during a non-key and non-critical portion of the procedure, he/she will be immediately available to return to the procedure if the need arises, or will arrange for another designated, attending-level physician to be immediately available to assist if he/she is unavailable for any reason.

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Place Patient Label Here

ADDITIONAL NOTES:

Your/your child's physician has recommended the donation and/or transfusion of an Emergency Celluar Product.

The product is considered an Emergency Cellular Product for the reason indicated below:

□The donor was screened for infectious disease and was negative. This screening is required to be completed within either 7 or 30 days before collection, depending on the product collected. The donor was not able to have repeat infectious disease screening studies completed within the required time. Infectious disease screening studies were completed before the donation of this product, but the results are not yet available. By signing this form, you acknowledge that you have been informed of the risks of donation of this product and accept it.

□The donor was previously screened and was negative for infectious diseases, but the results are out of date. The cellular product needs to be infused before the repeat infectious disease screening results are available. There is a risk that the donor has contracted an infectious disease that could be passed on through the cellular product. By signing this form, you acknowledge that you have been informed of the risks of transfusion of this product and accept it.

□The donor has completed a screening health history questionnaire. The donor has exhibited risk behavior, lived in, or traveled to, a country in which the chance of contracting an infectious disease is increased. There is a slight risk that the donor could have contracted an infectious disease that could be passed on through the cellular product. We believe that the risk is minimal, but not zero. By signing this form, you acknowledge that you have been informed of the risks of donation and/or transfusion of this cellular product and accept it.

□ Other: _____

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SPANISH (ESPAÑOL): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al *1-919-681-3007.*

CHINESE (繁體中文**):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 *1-919-681-3007.*

I certify that I have read this complete form (pages 1-2), or it was read to me, and that I fully understand the information on both front and back; that I have had the opportunity to ask questions, and the answers and additional information provided have met with my satisfaction.

_____ _____ _____
Signature of Patient, Parent (if a minor) or Legally Authorized Representative (LAR)* Date Time:

_____
Relationship to Patient (if other than the patient)

I certify that the patient/ parent/or LAR has answered "yes" to all of the following questions:
a) did your attending physician or his/her designee explain the procedure to you?
b) have all your questions about the procedure been answered?

_____M.D. _____ _____ _____ Witness
(Attending physician or designee) Pager# Date: Time:

*Order of consent for incapacitated adult: 1. Guardian (appointed pursuant to Article 5, Ch 35A of the NCGS), subject to the exercise of authority by healthcare agent described below; 2. Health care agent (appointed pursuant to Article 3, Chapter 32A of the NCGS), to the extent they have authority to consent and that authority has not been suspended by the Clerk of Court in appointing a Guardian as described above; 3.Attorney-in-fact with healthcare decision-making power (appointed pursuant to Articles 1 or 2, Chapter 32A of the NCGS), to the extent they have authority to consent; 4. Patient's spouse; 5. A majority of the patient's reasonably available parents and children who are at least 18 years of age; 6. A majority of the patient's reasonably available siblings who are at least 18 years of age; 7. An individual who has an established relationship with the patient who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

Signature Manifest

Document Number: APBMT-COMM-001 FRM1 **Revision:** 02
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All dates and times are in Eastern Time.

APBMT-COMM-001 FRM1 Request and Authorization Form for Emergency Release of Cellular Product

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Document Release

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