Trillium Gift of Life Network

First Person Consent to Donate Organs and/or Tissues

TGLN ID # ____________

A TO BE COMPLETED WITH PATIENT

I, ______________________________ , hereby consent to the removal of organs and/or tissues for the
NAME OF PATIENT (LEGAL FIRST AND LAST NAME)

purpose of transplantation as indicated in the box below:

Donated Organ(s) and/or Tissue(s) – Please choose Option 1 or 2 by selecting the corresponding box below

☐ **Option 1** All organs and tissues listed below	☐ **Option 2** Only the organ(s) and/or tissue(s) selected (☑) below
☐ Heart	☐ Eyes
☐ Kidney	☐ Bone and Connective Tissue
☐ Liver	☐ Heart for Valves; Pericardium; Aorta
☐ Vessels for future transplant	☐ Skin
☐ Lung	
☐ Pancreas	
☐ Pancreas (for islets)	
☐ Intestine	

Additional donated organs or tissue for transplantation (please specify in writing if indicated)

☐ **Other ______________________________

**this type of transplantation has been explained to me

Initials:

______________ INITIALS OF PATIENT

______________ DAY MONTH YEAR

______________ TIME

My above gift(s) may also be used for the purpose(s) I have checked below:

☐ **None** ☐ **Medical Education** ☐ **Scientific Research**

I understand that donated organs/tissues/blood/fluids will be used only for Research Ethics Board-approved studies related to donation and transplantation. Research may also include tissue connected to any of the organs or tissues identified above and also covers future research, which might include the possibility of stem cell or genetic research. I understand that Ontario Health (Trillium Gift of Life Network (TGLN)) will not be in a position to provide specific details on

how the donated organs/tissues/blood/fluids may have been used. In addition to any required collection of blood or fluid for research I also authorize the recovery team to remove (specify other organs/tissues) ___________________

The implications of transfer were explained to me and I hereby authorize transfer of my body for the following:

- Donor screening ☐ N/A ☐ Yes ☐ No Authorization for transfer
- Surgical recovery of the donated organ(s) ☐ N/A ☐ Yes ☐ No Authorization for transfer
- Surgical recovery of donated tissue(s) ☐ N/A ☐ Yes ☐ No Authorization for transfer

As required for the purpose of facilitating organ and tissue donation and transplantation, I agree to and authorize the following:

- The release of any personal health information from any of my patient records, as required for confirming eligibility for donation and between persons and organizations engaged in the donation, procurement, or transplantation of organs and tissues across jurisdictions
- Personal health information being shared if needed for health and safety reasons to persons and/or organizations engaged in organ and tissue donation and transplantation
- Collection and use of my blood and/or any body tissues (including from the spleen and lymph nodes) required to determine medical suitability of, or to assist in matching, organs and tissues for transplantation, including but not limited to tests for infectious diseases (e.g. HIV; Hepatitis B and C; syphilis) – these samples may also be used for the purposes of future testing
- Access by and release to Ontario Health (TGLN) or an associated tissue bank of any and all records and reports of a Medical Examiner, Coroner, Pathologist, or Primary Care Practitioner
- Photography of organs, tattoos, moles or other skin patterns or conditions by Ontario Health (TGLN) staff or transplant physicians, and the secure transmission of images for the purpose of medical suitability assessment
- I understand that all information will be kept confidential except where the law requires or permits the information to be shared

☐ Organ consent N/A – below text in box not applicable

Specifically for facilitation of organ donation, I authorize and consent to interventions that may occur throughout the duration of the donation process, including pre-mortem, to evaluate for medical suitability and optimize the outcome of organs recovered for transplantation. I understand that these interventions are of no therapeutic benefit to myself, and, in the opinions of the physicians responsible for my care, may present a minimal risk and will not be used or continued if there is any indication that death will be accelerated as a result.

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The organ and tissue recovery procedure has been explained to me. I am aware that the donated organs and tissue are a gift, and that no one will receive monetary compensation or valuable consideration for them. I have had the opportunity to ask questions about the procedure and have had my questions answered to my satisfaction. I understand the information and give consent as indicated on this form. I understand that this consent supersedes any prior written consent I may have given relating to donation.

☐ **Verbal/Phone Consent. Signature Not Applicable**
(PART C AND D MUST BE COMPLETED FOR VERBAL/PHONE CONSENT)

Signature: ______________________________ Date: ____________________ __________
SIGNATURE OF PATIENT *DAY MONTH YEAR* *TIME*

Ontario Health (TGLN) or an associated tissue bank may correspond with the designated contact as listed below following my death to provide information on the outcome of donation. Under circumstances where the law requires or permits specific information from my patient medical records or findings of my medical tests to be shared, the below-listed contact shall also serve as my designate for such correspondence.

Designated Contact Information:

____
DESIGNATED CONTACT FIRST AND LAST NAME

__________ ______________________________
UNIT/APT # *STREET*

__________ __________ __________
CITY *PROVINCE* *POSTAL CODE*

__________ ______________________________
PHONE # *EMAIL ADDRESS*

Additional names of Individuals who may, following my death, receive information on the outcome of donation:

FIRST NAME AND LAST NAME	*RELATIONSHIP*	*EMAIL ADDRESS OR PHONE #*	*SIGNATURE (OPTIONAL)*

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B Special considerations requested by the patient, and/or Coroner

C TO BE COMPLETED BY THE PERSON CONFIRMING OR WITNESSING CONSENT

I, ______________________________ in my capacity as ______________________

NAME OF WITNESS ROLE

have discussed the option of organ and/or tissue donation with ______________________

NAME OF PATIENT

as indicated on the selected consent situation.

I have explained the nature of the relevant procedure(s) and have answered all questions to the best of my ability.

Where the case requires the involvement of a coroner: Authorization to proceed with donation will be obtained from the Coroner and I have explained the implications of the coroner's involvement and directions to the patient (and designated contact, as applicable)

Where consent for scientific research has been obtained: I have explained to the patient (and designated contact, as applicable) that any scientific research is approved by a Research Ethics Board and may include the possibility of stem cell research, and that information about the research with donated organ(s) and/or tissue(s) will not be available.

Where transfer for recovery and/or donor screening is required: I have further obtained consent for patient transfer (or, after death, patient's body) to the diagnostic testing facility and/or recovery facility and have discussed implications of the transfer with the patient (and designated contact, as applicable).

Witness Signature: ______________________________ Date: ____________ ______

SIGNATURE OF WITNESS DAY MONTH YEAR TIME

D TO BE COMPLETED BY THE SECOND WITNESS FOR ORAL OR TELEPHONE CONSENT

☐ **Consent/Confirmation Given by Telephone:** **Date/Time of Call**: ____________ ______

DAY MONTH YEAR TIME

Second Witness for Consent (Telephone or Oral Consent)

______________________________ ______________________________

NAME OF SECOND PERSON WITNESSING TELEPHONE CONSENT/CONFIRMATION SIGNATURE OF SECOND WITNESS