

PENNSTATE



Cancer Institute

at Penn State Milton S. Hershey Medical Center

## Penn State Milton S. Hershey Medical Center

### CONSENT FOR OPERATION OR OTHER PROCEDURE

Condition For Which Treatment is Proposed: **Allogeneic Lymphocyte Donor**

1. I authorize my physician/practitioner, \_\_\_\_\_ (name) and/or such other staff physicians or resident physicians as my physician may designate, to perform upon me (or the patient identified above) the following operation or procedure (for procedures on all paired organs or extremities, the side of the body must be specified as *left, right, or bilateral*, without abbreviations): Peripheral Blood Lymphocyte Collection.

I understand that physicians designated by my physician, including but not limited to physicians in the Penn state Milton S. Hershey Medical Center post graduate residency program, may be performing important tasks related to my surgery in accordance with Penn State Milton S. Hershey Medical center policy and, in the case of resident physicians, based on their skill set and under the supervision of an attending physician.

It has further been explained to me that qualified medical practitioners who are not physicians may also perform important parts of my surgery or administer the anesthesia, but only to the extent such tasks are within their scope of practice, as determined by Pennsylvania law, and for which they have been granted privileges by Penn State Milton S. Hershey Medical Center.

In this consent form, the operation or procedure identified above is referred to as the "procedure". I understand that at the time of my procedure, circumstances may require changing which individual practitioners are involved in performing the procedure.

2. My physician/practitioner has discussed with me the items that are briefly summarized below:

- (1) I may undergo the following test and procedures to determine if I am eligible for this procedure,: Complete medical history and physical examinations, blood test for blood cell counts, blood chemistries, clotting test, liver and kidney functions, test for certain communicable diseases including but not limited to test for HIV/AIDS, chest X-ray, and an electrocardiogram to check the heart.

I will not be able to participate in the procedure if am pregnant or nursing. If I am a female and capable of having children, I will have a serum pregnancy test (blood test) performed. If I think I could be pregnant at any time during the treatment, I will inform my doctor immediately.

**I have the right to see all my test results.** The doctor will discuss these results with me. I give my informed consent to release my health information to the transplant physician and/or recipient as appropriate.

Patient ID Label

(2) Peripheral blood lymphocytes will be collected. In this procedure, my white blood cells and hematopoietic cells will be collected by a technique called leukapheresis. In order to perform leukapheresis, two needles will be inserted in my veins, or if I have poor veins, a central line catheter will be inserted into a vein in my chest. I understand that I will be asked to sign a separate consent form for the insertion of a central line. Each leukapheresis procedure will take approximately 4 hours to complete. During each leukapheresis procedure, I will also receive an infusion of calcium gluconate intravenously over 15 minutes at one hour and at three hours into the infusion. This is due to a possible decrease in my blood level of calcium during the leukapheresis.

(3) The material risks of the proposed procedure, including the risk that this treatment may not accomplish the desired purpose: It has been explained to me that the following risks and consequences are involved in this procedure and are listed below. Calcium Gluconate may cause a tingling sensation with intravenous use and possible fainting, mild decreased blood pressure, chalky taste, and vein irritation with rapid IV injection.

Possible risks associated with the use of central venous catheters include puncturing my lung, bleeding, decreased blood pressure and infection. Rarely, blood clots may form in a central venous catheter. Risk of the Peripheral Blood Hematopoietic Cell Harvest: Leukapheresis: Cytopenia (low blood counts) and anemia may occur. Anemia is from a low red blood cell count and the symptoms could include paleness of my skin, weakness and tiredness. Patients undergoing leukapheresis may experience signs of citrate toxicity which could include paresthesia (sensations of numbness, prickling or tingling), abdominal discomfort and nausea/vomiting.

(4) I understand that my participation in my relative's treatment is voluntary, and I am free to withdraw at any time. Refusal to participate in or withdrawal from this procedure will involve no penalty or the loss of benefits to which I am otherwise entitled, and will not prejudice future care of my family member

(5) The medically reasonable alternative treatments: It has been explained to me that the patient's condition could be treated with different drugs or drug combinations including other chemotherapy regimens.

(6) What may happen if the proposed procedure is not performed: My relative may not be able to receive a Donor Lymphocyte Infusion.

3. I am aware that, in addition to the risks specifically described above, there are other risks that are present with respect to any surgical procedure, such as severe loss of blood, infection, risks associated with anesthetic administration, cardiac arrest, and blood clots lodging in the lungs, any of which may require additional corrective surgery or result in death.

4. I understand that during the course of this procedure, unforeseen conditions may arise which could require the nature of my procedure to be altered, or that another operation or procedure be performed. I therefore authorize my physician, or other physicians designated by my physician, to provide such medical treatment, or perform such operation or procedures as are necessary and desirable in the exercise of professional judgment.

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5. It has been explained to me that there may be circumstances when information must be disclosed or report pursuant to law, such as if it is determined during the course of the procedure that I have tuberculosis, viral meningitis, or other diseases required to be reported to state and/or federal authorities such as the Pennsylvania Department of Health or Centers for Disease Control and Prevention.

It has been explained to me that my medical information will be kept confidential in accordance with the policies of Penn State Milton S. Hershey Medical Center.

6. I understand the goals and anticipated benefits of the proposed procedure and the likelihood of achieving those goals. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed procedure.
7. I agree to receive blood or blood products (red cells, platelets, plasma, cryoprecipitate, or granulocytes) if this need arises during my surgery. I understand that transfusions are not risk-free, although blood is carefully tested. The risks of transfusion include, but are not limited to: 1) fever, hives, or shaking chills; 2) infections: Hepatitis B, Hepatitis C, HIV (the AIDS virus), bacterial contamination/infection, and other, unknown infections; 3) reactions from a mismatch of blood types; and 4) transfusion associated lung injury (TRALI).

I understand that a transfusion can always be refused. The risks of not receiving transfusion therapy have been explained to me. I understand that receiving my own blood may be a possibility which I should discuss with my doctor.

8. I acknowledge that the information I have received, as summarized on this form, is sufficient for me to consent to and authorize the procedure described above. I have had the opportunity to ask questions concerning my condition, and about the procedure, alternatives and risks, and all questions have been answered to my satisfaction.

9. I impose the following limitation(s) regarding my treatment (if none, so state): \_\_\_\_\_

10. I authorize the staff of The Penn State Milton S. Hershey Medical Center to preserve for scientific or teaching purposes any tissues or parts which may be removed in the course of this procedure, and to dispose of them.

11. I authorize The Penn State Milton S. Hershey Medical Center to permit other persons to observe the procedure with the understanding that such observation is for the purpose of advancing medical knowledge. I understand that for certain procedures, representatives of device manufacturers may be present. I authorize the presence of such industry representatives if my physician believes it is appropriate. I further authorize Penn State Milton S. Hershey Medical Center to obtain photographic or other pictorial representations of the procedure, and to use such representations for scientific or teaching purposes.

**Patient ID Label**

12. I certify that all blanks requiring insertion of information were completed and any questions I had have been answered before I signed this consent form.

\_\_\_\_\_ provided the information summarized above and obtained the consent for the procedure.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ \_\_\_\_\_ AM  
Patient's Signature (or signature of person consenting on behalf of the patient)      Date      Time      PM

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ \_\_\_\_\_ AM  
\*Optional – Witness to Patient's Signature      Date      Time      PM

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ \_\_\_\_\_ AM  
Physician/s/Practitioner's Signature      Date      Time      PM

This consent is valid for up to 60 days from the date of the patient's signature unless there is significant change in the patient's condition or consent is revoked by the patient.

\*Use of a witness is at the discretion of the individual obtaining the consent.