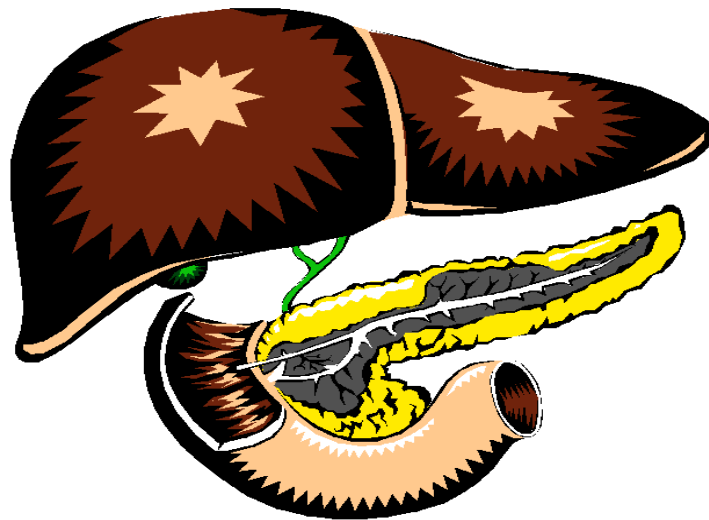


# LIVING DONOR LIVER TRANSPLANTATION INFORMATION FOR DONORS



University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

<b>Index</b>	<b>Page Number</b>
<i>Abbreviations.....</i>	<i>3</i>
<i>Prologue.....</i>	<i>3</i>
<i>Benefits and Risks for the Transplant Recipient.....</i>	<i>3</i>
<i>Principles Guiding the Assessment Process for Live Liver Donation.....</i>	<i>4</i>
<i>Living Donor Assessment Process.....</i>	<i>6</i>
<i>Expedited Work-ups.....</i>	<i>8</i>
<i>Anonymous or directed donation: The assessment process when there is no biological relationship or no longstanding emotional relationship between the donor and recipient.....</i>	<i>9</i>
<i>The Living Donor Operation: What is done and what to expect.....</i>	<i>9</i>
<i>Post-operative Care.....</i>	<i>10</i>
<i>Surgical Risks and Potential Complications.....</i>	<i>11</i>
<i>Results of Liver Donation at the UHN.....</i>	<i>12</i>
<i>The Next steps.....</i>	<i>13</i>
<i>Documentation of the Decision to be Assessed.....</i>	<i>14</i>

## ***Abbreviations***

Deceased donor	DD
Living Donor	LD

## ***Prologue***

This letter has been written to provide individuals considering liver donation (LD) with information about the rationale for living donation, the assessment process, the operation, post-operative care, and the alternatives, benefits, risks and special risks of this surgery. Please take the time to read this information carefully and completely. If you are interested in pursuing live liver donation, please sign the section on the last page of this document stating that you have read and understood this information, and submit the signed form to our live donor coordinator along with a completed health history.

Living liver donation in Toronto has been ongoing since 1990. Initially, live donation was only offered for treatment of children. In 2000 we changed our philosophy and offered living donor liver transplants for adults. To date, we have performed over 300 donor procedures. Detailed information about our program is provided below.

## ***Benefits and Risks for the Transplant Recipient.***

***Benefits.*** The option of living liver donation reduces the risk of health deterioration and death for patients who need a liver transplant. In Toronto, at any point in time, there are usually about 200 people waiting for liver transplantation. The waiting time for deceased donor (cadaveric) liver transplantation in blood group O patients listed in our program is more than 4 years. It is increasingly rare for a blood group O recipient to be transplanted while he/she is still well enough to wait at home. The waiting time for blood group A recipients is about 2 years. The waiting time for blood group B recipients is about 3 years. The waiting time for blood group AB recipients averages six to twelve months. In 2006, more than 80 people died during their work-up for liver transplantation or while waiting for a donor organ.

Living donation offers several advantages. First, it provides a unique opportunity to restore good health to a close friend or family member. Second, it provides the recipient with a high quality organ. Third, the transplant can be performed at an optimal time, before the recipient's health deteriorates unduly. Fourth, the option of live donation reduces the risk of death or disqualification while waiting for a transplant. In 2006, we compared survival rates from the time of listing in those patients who underwent live donor liver transplantation to those patients who underwent deceased donor liver transplantation or remained on the waiting list. At one year after listing, there was about a 15% survival advantage for those who underwent live donor liver transplantation.

***Risks.*** The 1-year recipient survival rates of liver transplantation using a living donor (LD) graft or a deceased donor (DD) are 85-90%; 5-year is about 80-85% recipient/graft survival. Although

graft function is usually excellent after living liver donation, there is an increased risk of surgical complications associated LD. The risk of leaks or stricture (narrowing) of the bile duct anastomosis (join) is 25% with LD versus 5-10% with DD). The risk of clotting of the hepatic artery thrombosis is 2% with LD versus 1% with DD). These complications can lead to graft loss or the requirement for more surgery but often they can be managed without the need for further surgery and without affecting long term graft function.

The anticipated one-year survival of LD recipients ranges from 50-95% depending on the recipient's health and diagnosis. If requested by a donor, we will ask potential recipients of living donor grafts for consent to provide you with recipient--specific information about the potential for disease recurrence and the anticipated rate of success of the transplant.

### ***Principles Guiding the Assessment Process for Live Liver Donation***

- The intended recipient must agree to living donation.
- Recipients of living donor grafts must satisfy the criteria for deceased donor liver transplants or meet expanded criteria for transplantation that are within predefined protocols that have been approved by our transplant team.
- The donor work-up usually does not start until the recipient has been listed for deceased donation. Potential recipients for living donation remain on the deceased donor waiting list while the living donor work-up is in progress. The opportunity for living donation does not affect the status of the recipient on the deceased donor list. Deceased donor organs are offered according to the standard allocation algorithm, regardless of whether or not the recipient has a potential living donor.
- Donors are usually between 18 and 60 years of age. They must be old enough to provide informed consent and young enough to have a healthy liver and no major health issues.
- The donor's primary goal should be to help the recipient. Living donation must be a voluntary choice without external pressure, coercion, or material gain.
- Donor safety is the most important priority during the assessment. Donation will not be offered if the medical and surgical team believes that the potential for harm outweighs the benefits. The duration of work up is determined by availability of healthcare resources, the donor's schedule, and the complexity of the donor's health issues. It may take days, weeks, or sometimes months to complete all of the necessary tests, and to confirm to the satisfaction of all health care professionals on our team that living liver donation is an appropriate and safe option.
- If more than one potential donor volunteers, the donor team will assess suitability based on health questionnaire and blood type. We will contact the most suitable donor to start assessment unless the intended donors meet and collectively instruct us otherwise.
- We expect donors to inform us of any concerns or issues that may need to be addressed regarding their assessment. All information obtained during the assessment is strictly confidential and will not be shared. If the screening questionnaire reveals major health

issues, we may ask the donor to provide consent to obtain reports from their doctor before starting the work-up.

- Donors need to be aware that previously undiagnosed medical conditions may be uncovered during their medical assessment. A new diagnosis could affect the ability to obtain insurance or employment and/or cause emotional distress.
- OHIP pays for the direct costs of liver donation. However, neither OHIP nor the hospital will compensate donors for time lost from work, travel expenses, outpatient medication costs, etc. If a donor travels from another country to donate; only assessment tests, physician, and hospital costs are covered by the recipient's OHIP. Travel costs are not covered nor are the costs of any investigations or follow-up done in their country of origin. Donors who pay into Employment Insurance may be eligible for Employment Insurance Benefits at the time of donation. There is also a living donor reimbursement program, funded through the Ministry of Health and Long-term Care, aimed at minimizing the costs incurred by living donors. Our program will be happy to provide further information regarding this initiative or donors can obtain more information on the Trillium Gift of Life Network website (<http://www.giftoflife.on.ca/>). The Living Donor Office would be pleased to arrange a Social Work consult regarding these issues should a donor wish to make an inquiry.
- Our program will consider out of country donors on a case-by-case basis. We do not accept donors from countries in circumstances when high quality ongoing medical follow-up cannot be guaranteed or when it is difficult to obtain supporting data to confirm that beneficence (doing good) and / or altruism (helping someone else without material gain) are the primary motivations of the donor.
- In some circumstances, living liver donation is not possible or appropriate. The final decision to perform the living donor transplant rests with the transplant doctors. The physicians and members of the transplant team must consider their own ethical and moral responsibilities when deciding to accept or reject a potential donor. There is no obligation for the transplant team to perform a living donor surgery but if we decide that live donation is inappropriate, we will offer referrals to other programs for a second opinion.
- For living organ donation to proceed, there must be agreement between the donor, recipient, and the medical team. Unusual ethical issues may be taken to the Transplant Ethics Committee for review and advice.
- We will forward copies of all test results done during your assessment to your family doctor at the end of your assessment and/or surgery.
- If you wish to speak with someone who has undergone the liver donor surgery please let the office know and we will arrange an opportunity to speak with one of the past donors

### *Living Donor Assessment Process.*

It is the donor's responsibility to submit an honest and complete health history and blood type to the Living Donor Office. Completed histories will be reviewed and donors will be contacted to assess interest in proceeding. It is also the donor's responsibility to inform the donor team of any homeopathic or herbal remedies as these may interfere with liver function.

Candidates for liver donation must be in excellent physical and emotional health. A history of cancer and/or an active infection are contraindications to organ donation. The donor must have normal or near normal liver function. The liver must have a pattern of blood supply and a distribution of bile ducts that are suitable for transplantation. Donors should have family or friends that can provide support before, during and after the surgery. Donors are required to have a family physician.

Before starting a work-up we ask potential donors to confirm that they will be available to undergo the donor surgery within the next 3 weeks to 3 months provided 1) no contraindications are found and 2) they still want to proceed after learning more about the procedure.

**Smoking and the birth control pill are avoidable risk factors for blood clots after surgery.** Therefore, for non-urgent donation, we ask donors to stop smoking for at least two weeks prior to donation. We also ask women using any form of hormonal birth control or replacement therapy to stop this medication and use two alternative forms of contraception for 4 weeks before donation.

If a contraindication is found the donor is notified and the work-up is stopped. The results of the health tests performed during the work-up are sent to the family doctor with a request that he/she follows up these tests. If a reversible contraindication is corrected (a fatty liver for example) the work-up can be restarted.

The work-up is outlined below. The team assessing the donor is specifically focused on protecting the donor's interests and well being. The screening tests are organized by the Living Donor Office. **Blood type (ABO) compatibility must be established before any testing is performed. This is to be submitted with the donor history; the Living Donor Office will facilitate obtaining your blood type upon request. Both blood type and donor history need to be provided prior to proceeding with the donor evaluation.**

Blood samples are obtained to confirm normal organ function and test for the presence of several viral diseases including but not limited to Hepatitis B and C, HIV and Syphilis. **Please note that some viruses are reportable by law to the Public Health Department. You may be contacted by Public Health if you have tested positive for these viruses.**

An electrocardiogram and a chest x-ray are obtained to confirm normal heart and lung function. If these studies are normal then CT (computerized tomography), ultrasound, and MRI (magnetic resonance imaging) scans are arranged at the Toronto General Hospital. The surgeons then review these tests to ensure that the liver is healthy and the anatomy is suitable for transplant

surgery. In some cases further studies are required such as a liver biopsy or an x-ray of the bile ducts (CT cholangiogram).

If the screening blood work and scans are satisfactory. The potential donor is offered a tentative target surgery date based on their availability. Once a target date is defined the potential donor will complete a number of consultations with other health care specialists. The potential donor is seen by a psychiatrist, an independent medical doctor who does not work directly with the transplant team, and one or more of the transplant surgeons. A medical assessment is obtained to determine the medical risks associated with liver donation for each individual. Sometimes these consults will identify the need for additional testing to be done. The transplant team decides whether liver donation is possible or inappropriate. These consultations provide potential donors with a confidential opportunity to opt-out or decline liver donation for medical, social, or personal reasons without having to provide an explanation to the intended recipient. If this is the case the recipient and their team are informed that the donor in assessment was deemed to be medically unsuitable.

Donors usually meet with two different surgeons during the assessment period to discuss the surgery in detail. The first appointment takes place earlier in the process. The second one occurs when the work up has been completed. During either the first or second meeting with a surgeon the donor is asked to sign an informed consent form after reviewing the surgery, benefits, risks, and alternatives. The surgeon who obtains this consent may not be the one who performs the operation. A different surgeon than the one who performed the operation may provide post-operative care.

The donor team may decide it is not possible for a donor to proceed for a variety of reasons that are discussed with the donor in detail. Currently only about 20% of those who indicate an interest in liver donation actually undergo this surgery. Some of the more common reasons for not proceeding to surgery include unsuitable blood vessel structure, abnormal blood tests and medical problems not previously identified such as diabetes. Some potential donors may decide that proceeding with living donation is not appropriate for them after starting their assessment. Donors are supported in whichever decision they make. At any stage the potential donor or the health care team may decide that it is not suitable to proceed with liver donation. Unless specifically requested by the donor, recipients are not given information on the reason why a donor is unsuitable, thus protecting the confidentiality of the donor.

If a potential donor does not attend a required test, the test will be re-booked and the donor informed by telephone. This may be done twice. If the donor fails to come for the same test three times a letter will be sent requesting that the donor call the coordinator to rebook. If we do not hear from the donor within two weeks of sending this letter the transplant centre will assume that the donor does not wish to proceed with the workup. The recipient team will then be informed that the donor is not suitable at this time and that a work-up on an alternate donor may commence.

Potential donors must communicate directly with us regarding questions/concerns with their assessment. We will not communicate with third parties (family members, friends, recipients, etc).

There is a risk of transmitting infections via organ donation. Potential donors should immediately report any fever, flu-like illness or neurological symptoms. If a donor has active infection they should not donate part of their liver because they could transmit this illness to the recipient. To minimize the risk of disease transmission we obtain blood tests to check for infections at the start of the donor assessment and again a few days before the surgery date. Donors should also: 1) take steps to avoid disease transmission through sexual contact (condoms); and 2) avoid being bitten by mosquitoes, which could transmit the West Nile virus infection, by wearing long sleeve shirts and pants and using mosquito repellent.

Alcohol and marijuana must be avoided completely for 4 weeks before surgery and for at least 8 weeks after the surgery.

### ***Expedited Work-ups***

Expedited workups for urgent living donation are only undertaken in exceptional circumstances – **usually for adults with acute liver failure or children with rapidly deteriorating liver function where death is expected to occur within hours to several days.** This circumstance requires a very careful assessment due to the higher than usual risk of coercion and/or difficulties obtaining informed consent. Issues that will be considered when contemplating an expedited donor assessment include:

Expedited donor assessments are not the standard of care. We restrict expedited workups to circumstances where there is a close biological relationship and / or longstanding emotional relationship between the donor and recipient.

Regardless of the pace of deterioration of the intended recipient, we will not take short-cuts. The pace of the workup will be determined by a) available hospital resources; b) the time that the donor assessment team believes is required to ensure informed consent is obtained; and c) the time required to complete a thorough work-up.

Potential donors must understand and accept that the risks of donation may be slightly greater in urgent circumstances (for example, there might be a higher risk of pneumonia or blood clots if the donor does not have time to stop smoking or to stop the birth control pill).

Donor surgery will only be performed during the day-time when the donor surgeons are well rested and all necessary resources are available to perform this surgery at the highest possible standard.

The option of live donation for rapidly deteriorating recipients will not be offered when it is believed that the probability of recipient survival is less than 50%.

***Anonymous and/or directed donation: The assessment process when there is no biological relationship or no longstanding emotional relationship between the donor and recipient.***

Additional conditions may be imposed in circumstances where there is no biological relationship and / or no longstanding emotional relationship between the donor and recipient. In this circumstance, some but not all of the potential issues that will be considered include:

Individuals may be asked to agree to maintain their anonymity according to the program guidelines. This requirement serves to protect both the interest of the donor and the recipient and their family. If at some point in the future both parties are interested in meeting, our program may facilitate a meeting after a waiting period of at least 6 months.

Directed donation will be considered but our program reserves the right to insist that the offer to donate will only be accepted if the liver is given to the patient with the greatest medical need. For example, our program will refuse to accept a directed donation that was based on the ethnic group, skin color, or religious conviction of the recipient.

We may use different criteria to allocate live donor livers compared with deceased donor livers. When donation is not directed, we will consider anatomic issues; relative recipient risks of right or left lobe donation; medical need of potential recipients; and probability of recipient benefit when allocating the liver.

***Living Donor Surgery: What is done and what to expect.***

The target surgery date is always tentative and subject to change. In 2007, the planned surgery date was changed in approximately 50% of cases. Reasons for changes include: 1) the potential donor may confidentially opt out of donation at any time; 2) the liver transplant program may change the target date if the program believes that other live donor cases should take priority because of medical urgency or if the program does not have sufficient resources available for safe donation; 3) resource limitations (availability of hospital beds and nurses primarily). When a donor surgery is cancelled, we re-schedule the surgery as soon as possible.

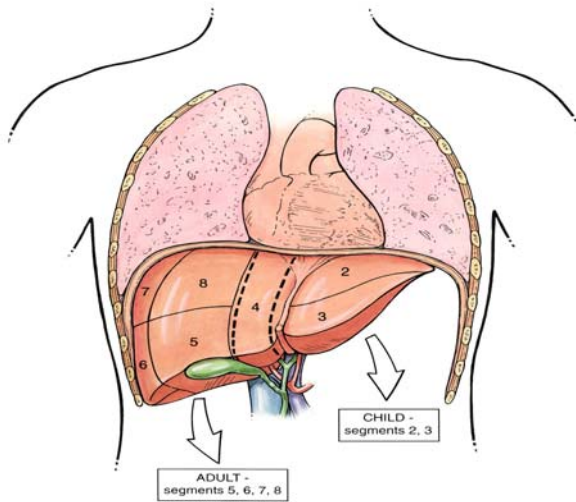
If a donor needs to travel by airplane to have the surgery we ask that they complete their air travel at least two days before the surgery. Sitting in an airplane for a prolonged time increases the risk of blood clots during and after the surgery.

Donors are admitted to hospital at 6:00 AM on the morning of surgery. No food or fluids are allowed after midnight the night before your surgery. After arriving you will change into a hospital gown and be measured for compression socks. An intravenous will be inserted into your arm. Your blood pressure and temperature will be checked. Anesthesia will come and speak to you regarding pain management and you will then be transferred to the OR. You will receive antibiotics and a blood thinner to prevent blood clots. After you are asleep (anesthetized), various tubes will be inserted to drain the contents of your stomach and bladder, to provide intravenous fluids, and monitor your blood pressure.

Surgery begins with a careful examination of the internal structures including an intra-operative ultrasound and an x-ray of the bile duct. After removal of the gall bladder the surgeons expose the blood supply and bile ducts to the part of the liver that is going to be removed (see diagram below). Sometimes at this point, despite satisfactory preoperative tests, we find a pattern of

blood vessels or bile ducts that would make the transplant unusually risky for the donor or the recipient. In this situation we do not proceed with the donor surgery and the incision is closed. This happens in about 3-5% of donor surgeries.

Once donor anatomy is confirmed suitable the recipient OR will start. The donor liver tissue is divided as described below. The operation lasts 6-8 hours. Following surgery the donor goes to the recovery room for 2-3 hours and then returns to the step down unit.



Right lobe donation involves removing segments 5, 6, 7, and 8. Left lateral segment donation involves removing segments 2 and 3. Left lobe donation involves removing segments 2, 3, and 4. The liver grows back to its normal size in about 6 weeks.

Artist: Stephen Maider. © Copyright 2003. Property of UHN. This graphic cannot be reproduced or used for other purpose without permission.

### ***Post-operative Care***

Liver donors are cared for by a transplant team that includes surgeons, medical physicians (liver specialists), nurses, pain specialists, and nurse practitioners. Toronto General Hospital is a teaching facility therefore your health care team will involve nurses and physicians who are training.

Post-operative pain is managed by either a patient controlled analgesia pump or an epidural catheter. After 2-4 days oral pain relievers such as Tylenol #3 are prescribed. The pros and cons of the different methods of pain control will be reviewed by the anesthetist at the time of the pre-admission visit.

Most donors are discharged from hospital about 5-7 days after the operation. Drainage tubes inserted during the surgery (nasogastric tube, intravenous, bladder catheter) are gradually removed over the first few days. Most patients are able to start eating and drinking about the 3rd to 5th postoperative day. Liver function blood tests are monitored during your hospital stay and after leaving hospital. An ultrasound is also done before discharge.

Donors may develop mild jaundice after the donor surgery. The jaundice usually resolves without any treatment but if it persists or becomes more severe, patients may require an ultrasound study or special x-rays of the bile ducts (ERCP) to rule out complications.

Donors are placed on a blood thinner after surgery, which requires a daily injection during your hospital stay and for 5 weeks after discharge from hospital. It is important to walk frequently after surgery in order to reduce the risk of forming blood clots. Due to the increased risk of blood clots we ask donors to:

1. Avoid air travel or prolonged car trips for 2-4 weeks postoperatively
2. When traveling for the first 2-8 weeks after donor surgery, take time to walk every hour for approximately fifteen minutes to promote blood flow in your legs.

The remaining liver segment grows and resumes normal function after donation. Most complications are apparent soon after surgery but some complications can develop following discharge from hospital. Donors should contact the donor office immediately if they develop new abdominal pain, redness or swelling around their incision, yellow skin, a fever, cough or shortness of breath. If the donor office is closed go immediately to the nearest Emergency Department. Signs and symptoms will be reviewed during your discharge teaching.

Follow-up clinic visits are arranged 2 and 4 weeks after surgery. At these visits you will have blood work done and be seen by a medical physician and transplant surgeon respectively. It is common to experience a “letdown” or mild depression at the 4-6 week period while recovering from surgery. This usually resolves quickly but support is available if this occurs. We will continue to follow you closely.

We support donors being off work from 6-12 weeks depending on the nature of their employment. It usually takes three to four months before patients are able to return to all of their normal activities at their usual stamina level.

Patients will be reviewed by their surgeon at least once after surgery in the out-patient clinic. The remainder of the follow-up care is provided by a medical physician, the donor coordinator and your family doctor.

### ***Surgical Risks and Potential Complications***

Liver donation is associated with significant risks no matter how carefully the donor surgery is performed. It is vital that persons considering donation have a good understanding of the nature of this surgery, the benefits, the risks, and the alternatives. Risks are discussed frequently during assessment and are carefully reviewed during visits with the surgeons. Feel free to ask for additional information. Some of the risks of live donation are outlined below.

- Liver donation is challenging surgery. Donor deaths and/or severe complications can occur even when the very best care is provided. The risk of death is estimated to be 0.15% with left lobe donation and 0.30% with right lobe donation. Approximately 30% of patients will experience a complication, usually temporary. To provide perspective, it is worth noting that the risk of death is higher after live donation than the risk after routine heart by-pass surgery, for example.

- The surgery is performed through a large upper abdominal incision that results in mild, permanent weakness in the abdominal wall and a small patch of numbness beneath the incision, just above the umbilicus (navel).
- **Up to 30% of liver donors will experience complications, usually temporary. Some, but not all, of the risks of this surgery include: an adverse reaction to anesthesia; a decision to abandon the donor surgery based on intra-operative findings (about 5% of cases); stroke; heart attack; blood clots in the legs or lung; fluid around the lung (pleural effusion); fluid retention (edema); mild or severe infections; infection or other adverse effects of a blood transfusion (required in about 5% of cases); re-operation (about 5% of cases, usually due to bleeding); bile leakage; injury to adjacent organs such as the spleen, stomach, or intestine; an injury to the remaining liver segment's blood vessels or bile ducts resulting in liver failure; severe depression; unsightly scar; retractor injuries causing temporary or permanent nerve damage; or persistent incisional pain. Several donors in the United States and Japan have required liver transplantation for the treatment of liver failure that has developed after donating part of their liver.**
- If complications occur, they could impair the donor's ability to obtain health or life insurance as well as affecting the donor's lifestyle and/or ability to maintain or obtain employment. Potential donors should consult an insurance agent and/or speak to their employer about the surgery itself, which even without complications, might impact on their insurability or job security. Staff from the transplant program will be pleased to provide any information that is required.
- No matter how carefully the transplant is performed, there is the potential that the liver recipient will die during or after the transplant surgery. If this happens, donors will know that they have done everything possible to help a loved one. Nonetheless, potential donors should consider carefully how you might respond to the stress of dealing with the recipient's death. In the highly unlikely event that your liver segment has been removed and your intended recipient develops a complication that makes transplantation impossible, (a so-called "orphan" graft exists) we will try to place your liver segment into another recipient. Worldwide this problem has only happened a few times; it has never happened in Toronto so far.
- Unforeseen problems may be identified as we gain further experience with this operation.

### ***Results of Liver Donation at the UHN***

*Outcomes of donor surgery:* Over 300 donor liver procedures have been performed at the UHN from June 1996 to September 2007 with no deaths and no persistent long-term ill effects so far. Median operative time was 390 minutes, estimated blood loss was 500cc and there were no intra-operative complications. As expected with major surgery many donors experienced complications. Donors have had unsuitable anatomy and the plan to remove the liver segment was abandoned. The frequency of early post-operative donor complications was 16%. Early post-operative bleeding requiring re-operation occurred in (3%); these were among the only patients who required blood transfusions from someone else. Other morbidities include (1.8%) with bile leaks that required endoscopic treatment, (3.6%) with abscesses or fluid collection

requiring insertion of a drainage tube in the radiology department (1.8%) with blood clots to the lung (pulmonary emboli) and (2.2%) of patients with wound incision hernias that required repair.

*Outcomes of recipient operation (live donor liver transplantation):* Patients receiving live donor liver transplants have done well. Survival after live donor liver transplantation has been similar to survival after deceased donor liver transplantation (~90% at one year). There has been a higher rate of bile duct complications in live donor recipients compared with deceased donor recipients (~20% versus ~5%) but most of these complications have resolved with non-surgical management.

### ***The Next steps***

Individuals who want to be assessed for living liver donation should read and sign the attached pages and return the signed document to the Living Liver Donor Office – see below. The Living Liver Donor Office will coordinate your assessment. Please let us know if you have any questions.

Toronto General Hospital  
Living Liver Donor Assessment Office  
585 University Avenue  
NCSB-12C 1217  
Toronto, ON M5G 2N2

## **DOCUMENTATION OF THE DECISION TO BE ASSESSED FOR LIVER DONATION**

### **SUMMARY**

I understand that liver donation surgery entails significant risks and offers no direct medical benefit to the donor. I understand that I may obtain more information about living liver donor transplants from the Multi-Organ Transplant Program Website located on the UHN website [www.uhn.ca](http://www.uhn.ca) or by talking with the coordinator or one of the physicians or surgeons. If I undergo the donor surgery I understand that I will require careful follow-up and that the Toronto General Hospital Transplant program will contact me from time to time after this surgery to inquire about my health, insurance, employment and overall well being.

### **CONFIDENTIALITY**

Hospital personnel who are involved in the course of my care may review my medical record. They are required to maintain confidentiality as per law and the policy of UHN. I understand that if I do become a donor, data about my case, which may include my identity, may be sent to other places involved in the transplant process as permitted by law. I also understand that aggregate donor data, without individual identifiers, may also be shared as part of our research or for purposes of public presentations.

### **SIGNATURES**

I have received and read the Living Donor Liver Transplantation Information for Donors. I understand the risks, benefits and alternatives to living liver donation. I wish to proceed with the evaluation to find out if I can be a donor.

---

Printed Name of Potential Donor

---

Signature

---

Date

---

Printed Name of Witness

---

Signature

---

Date