NORTHWEST Kidney Centers

Northwest Kidney Centers Informed Consent for Treatment for Non-ESRD (AKI) Patients

I have the right to make decisions about my healthcare. My kidney doctor (nephrologist) has explained to me that I have a form of kidney failure called acute kidney injury (AKI).

By signing this form, I authorize Northwest Kidney Centers (NKC) to treat my kidney failure with hemodialysis treatments at the direction of my doctor and/or any other doctor appointed by him or her.

Information about my kidney failure (AKI)

- My kidney doctor has explained my kidney failure to me
- My kidney doctor told me what to expect from hemodialysis, the effects of treatment, and the risks of dialysis treatments
- NKC provides the hemodialysis treatments my kidney doctor has ordered for me
- NKC staff are available to answer any questions I might have about my kidney failure and/or treatments and will support the choices I make regarding my treatment

Kidney function and dialysis

I know my kidneys are not currently able to clean the wastes and extra fluid from my blood. Since my kidneys are not working, I need dialysis as a lifesaving treatment. I am not able to live without dialysis.

During hemodialysis my blood moves through tubing connected to me and is passed through a filter (dialyzer) and returned back to my body. The dialyzer removes waste products and extra fluid from my body.

I understand that during dialysis, a medication called heparin is used, which is derived from pork. I am aware I can refuse to have heparin given during my treatment and that my doctor will be contacted. I understand that NKC encourages me to discuss this matter or seek advice from my religious leaders if I have concerns.

NKC services

- Hemodialysis provided at an NKC dialysis center
- Laboratory draws to determine how well my dialysis is working and whether my kidneys are recovering
- Medications or special diet needs will be ordered specifically for me by my kidney doctor

Patient Name _____ **NKC#** _____

NKC services (continued)

- Care and services will be provided by NKC staff: nurses, technicians, social workers, dietitians, pharmacists, financial case managers, and other support staff as needed
- Doctors doing advanced studies in the care of kidney patients from the University of Washington may also take part in my care
- New employees or other students may provide care under the supervision of NKC staff

Unexpected medical needs

I know that during my treatment, unexpected situations may occur that require additional care. In these unusual circumstances, I authorize my doctor or his/her designee to order care for me to be performed by NKC staff.

Treatment choices

- I have the choice to not start dialysis, or to stop dialysis treatments at any time
- NKC staff is available to discuss these choices at any time and will support my choices
- I understand that stopping or not starting dialysis treatments may result in my death

Risks of dialysis

I understand that dialysis is a lifesaving treatment, but it also has risks which can be serious and even cause coma or death.

The risks can include:

- Low blood pressure (symptoms may include feeling weak or faint, headache, nausea, vomiting, chest pain or falls)
- Cramping from fluid removal (usually in legs, feet, hands)
- Chest pain
- Irregular or fast heart rate
- Fever and/or chills (may be a sign of infection)
- Infection of blood or dialysis access site
- Clotting of the blood at the access site, the dialyzer, or the blood tubing
- Bruising or bleeding due to blood thinning medications used in hemodialysis
- Allergic reactions which can cause itching or more serious symptoms
- Reactions and side effects from medications that are given during dialysis
- Hemodialysis equipment problems

Financial responsibility (see also Patient Account Agreement)

I agree to pay for all services provided by NKC according to the then current rates and terms of the facility.

I agree to apply for and use all available funding sources that are needed to pay for NKC charges and I understand that NKC will provide a Financial Case Manager to assist me with applications for funding sources, as necessary.

I agree to provide NKC with any financial and personal information needed to obtain and maintain coverage from funding sources. I agree to pay any applicable charges not paid by funding sources.

I agree to notify NKC about any changes in funding sources, including but not limited to, loss of or change in insurance coverage, eligibility for new coverage or enrollment in Medicaid or other programs.

Privacy of medical records (see also Notice of Privacy Practices)

I have received and understand the Northwest Kidney Centers Notice of Privacy Practices.

I understand that information in my medical record is protected and private and can only be shared under certain conditions that affect my medical care.

Duration of consent

I understand this consent will stay in effect for all treatments at any NKC facility, even if the care is interrupted due to hospital stay. If I regain kidney function, this consent will stay in effect for three months following my last treatment at NKC. I can cancel this consent in writing at any time and NKC can cancel it in writing at any time.

Patient Name _____ **NKC#** _____

NORTHWEST Kidney Centers

Northwest Kidney Centers Informed Consent for Treatment for Non-ESRD (AKI) Patients Acknowledgement

By signing this form I certify I have read, or someone else has read to me, the **Northwest Kidney Centers Informed Consent for Treatment for Non-ESRD (AKI) Patients** (CKD-PE-62, 1/01/2023). I have received a copy, have had any questions answered, and I understand the information.

Signed:

_____
Patient Name (Print)

x _____ _____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney Date

_____
Witness Name (Print)

x _____ _____
Witness Signature Date

x _____ _____
☐ Translator ☐ Reader Date

If this form is signed by someone else, there must be two witnesses:

_____
Witness Name (Print)

x _____ _____
Date