This form is being used as your planned treatment for end stage kidney disease is satellite or hospital haemodialysis.

**Haemodialysis** is a treatment for end stage kidney disease that removes the extra water and waste products from your blood via a fistula, graft or catheter.

### How do I use this form?

This form is a checklist of all the information your kidney doctor or nurse should give you to help you decide on your ongoing treatment. Please check each box as they talk you through it. You can use this to ask questions too.

### What am I signing?

By signing this form you are giving ‘informed consent’. This means you understand the information and agree with the information given to you.

### If you do not understand something

Please ask your kidney doctor or nurse. You can also ask for an interpreter.

## Information checklist

|  | My kidney doctor/nurse has informed me: | |
| --- | --- | --- |
| Condition |  | About my condition, end stage kidney disease. This means my kidneys are severely and permanently damaged. |
|  | About the likely outcome with and without dialysis. |
| Treatment options |  | About possible treatment options, including:   * haemodialysis in a healthcare facility * home haemodialysis * peritoneal dialysis * supportive care without dialysis (conservative care). |
|  | That I can request an assessment to see if I am suitable to receive a kidney transplant. And to do this, I should speak to my kidney doctor or nurse. |
| Risks and complications |  | About possible risks and complications of haemodialysis treatment. These can include:   * bleeding or blood clotting * infections * problems with the dialysis equipment. |
|  | That sometimes haemodialysis might not work for me. This could be because of:   * failed access to my blood * poor heart function * failure to improve my quality of life. |
| Rights and responsibilities |  | About my rights as a patient, including the right to:   * privacy * be treated with respect and dignity * be involved in decision making regarding my care * receive high-quality care and information. |
|  | That I can help achieve the best possible outcome by participating fully in my treatment. I understand I will need to:   * have regular blood tests * take medications as prescribed by my kidney doctor * attend scheduled medical appointments * cooperate with my dialysis treatment and my treating team. |
|  | That I need to conduct myself appropriately while in the health service and show respect for staff, other patients, visitors and volunteers. |
| Regular monitoring for infections |  | That I will need regular blood testing to monitor my health and how I am responding to the treatment. I will also be regularly tested for infectious diseases that can affect dialysis patients, such as hepatitis B and C. |
|  | That I may also be tested for other infections, if I, or someone else, has potentially been exposed. |
| ANZDATA registry |  | That my health service will send health information about me to the Australia and New Zealand Dialysis and Transplant (ANZDATA) registry.   * This information is used to improve the quality of care and outcomes for people with end stage kidney disease in Australia and New Zealand. * I can talk to my kidney doctor or nurse if I do not want this to happen. |
| Communication of clinical information |  | That my health record and information (both electronic and written) will be shared with staff from this health service and any other service I go to. This is to help coordinate my care, no matter who is helping me. |
| Treatment change |  | That I can change the type of treatment I am having, and that this is sometimes recommended. |
| Stopping treatment |  | That if dialysis treatment is no longer of benefit to me, there is the option of stopping dialysis and being managed with supportive care without dialysis (conservative care). |
| Advance care planning and goals of care |  | About the benefits of discussing and documenting treatment plans in case my condition worsens in the future (advance care planning). I have been informed of the importance of communicating with the treating team about my goals of care. |

**Patient consent** (To be filled out by the patient, **or** their medical treatment decision maker.)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Patient | | OR | | Medical treatment decision maker | | |
| I have read and/or had explained to me the contents of this form and I understand the information in it.  I have been informed of all my treatment options for end stage kidney disease and I have had the opportunity to ask questions.  My planned treatment option is…………………………………………………………………………………………………………  (insert planned treatment here).  I give my consent to this ongoing treatment and to what is explained above. | | | | | | |
| Signed: |  | | Signed: | |  | |
| Name: |  | | Name: | |  | |
| Date: |  | | Date: | |  | |
|  | | | Relationship to patient: | | |  |
|  | | | Reason why you are giving consent for the patient: | | | |
|  | | |  | | | |

**Confirmation** (To be filled out by members of the patient’s medical team.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Education and information | | | Informed consent | | |
| I confirm that the patient (or their representative) has received sufficient education and information about the available treatment options for managing their end stage kidney disease. | | | I am satisfied that the alternatives and risks have been explained to the patient (or their representative). I believe that this information has been understood and that informed consent has been given. | | |
| Signed: | |  | Signed: | |  |
| Name: | |  | Name: | |  |
| Date: | |  | Date: | |  |
| Designation: | | | **Designation:** | | |
| ☐ | chronic kidney disease educator (or equivalent senior renal nurse) | |  | nephrologist | |
| ☐ | renal registrar | |
|  | nurse practitioner | |  | Name of the treating nephrologist: | |
|  | renal registrar | |  |  | |
|  | nephrologist | |  |

**Interpreter** (To be filled out if an interpreter was provided.)

|  |  |  |  |
| --- | --- | --- | --- |
| Face-to-face interpreter | | Phone interpreter | |
| Interpreter’s name: |  | A staff member’s signature is required to confirm a phone interpreter was used | |
| Signed: |  | Signed: |  |

|  |  |
| --- | --- |
| This form was developed for Victorian renal health services and adapted with permission from Safer Care Victoria. For more information, download the ‘Standardised informed consent for maintenance dialysis’ policy and other consent forms at **safercare.vic.gov.au.** |  |