



CONSENT / REFUSAL TO BLOOD PRODUCTS

I have been advised that I may need a blood / blood product transfusion. The reasons I require transfusion have been explained to me as follows: _____

I _____ consent to / refuse _____ the administration of blood products.
(circle one)

Risks include but are not limited to chills, fever, itching or other allergic reactions and possible exposure to infectious agents such as Hepatitis B or C viruses and Human Immunodeficiency Virus. Possible alternatives include no transfusion, self-donation, intravenous fluids, recycled blood, use of blood formation agents such as erythropoietin and iron.

The consequences of refusing blood products have been fully explained to me. I understand that my refusal may cause serious illness and possible death.

I have read the entire document and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

Signature of Patient, Parent*, Guardian*, Health Care Agent* or other representative of patient*.

Relationship: _____ Date: _____ Time: _____

* If other than patient, provide reason: _____

Signature of Witness (Age 18 or older other than practitioner performing procedure)

Title or relationship to patient _____ Date: _____ Time: _____

Statement of Practitioner obtaining consent: *I certify that I have explained the risks, benefits and alternatives to this procedure to the patient or patient's representative and have answered any questions.*

Practitioner's signature _____ / ID # _____ Date: _____ Time: _____

Use Of Interpreter or Special Assistance

An interpreter or special assistance was used to obtain consent from this patient as follows:

____ Foreign language (specify) _____

____ Sign language

____ Patient is blind, consent form read to patient

____ Other (specify) _____

Interpretation provided by:

(Name of interpreter and title or relationship to patient)

Practitioner's signature _____ / ID # _____ Date: _____ Time: _____