



RM2C011



Stony Brook
Medicine

Stony Brook, NY 11794

CONSENT / REFUSAL TO BLOOD PRODUCTS

I have been advised that I may need a blood/blood product transfusion. I know that the transfusion will be for one or more reasons that may include: To correct anemia, to increase the oxygen delivery to the body, to help my blood clot or to prevent bleeding. I have been told what a transfusion is and how it will be done. The possible blood products may include:

- | | |
|---------------------------|----------------------|
| 1. Red blood cells | 4. Granulocytes |
| 2. Platelets | 5. Stem cells |
| 3. Plasma/cryoprecipitate | 6. Mononuclear cells |

I understand that there are risks associated with blood transfusions. These include: Bruising, fever, chills, rash, hives or other allergic reactions, kidney failure, heart failure, shortness of breath, possible exposure to infectious diseases such as hepatitis or HIV/AIDS.

Possible alternatives include: no transfusion, self-donation, intravenous fluids, recycled blood, use of blood formation agents such as erythropoietin and iron. I understand about the benefits of blood transfusion, the risks of not receiving the transfusion, the alternatives and the risks of the alternatives.

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

_____ I **consent** to the administration of blood products. I have been told about and acknowledge the risks and consequences of a transfusion and I want to receive any medically necessary transfusions during my hospitalization or course of treatment.

OR

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

Signature of Patient, or representative of the patient*, if patient unable _____

Relationship: _____ Date: _____ Time: _____

* If other than patient, provide reason: _____

Signature of witness (Age 18 or older, not the practitioner doing the procedure)

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

Statement of Practitioner obtaining consent: I certify that I have explained the risks, benefits and alternatives of this procedure, including the risk of refusing, to this patient or their 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) _____

Name of interpreter _____

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