CONSENT / REFUSAL TO BLOOD PRODUCTS

I have been told that I may need blood products. I know that giving me blood will be for one or more reasons that may include: To correct anemia (not enough red blood cells in my body), to increase the amount of oxygen in my body, for blood loss during a medical procedure, to help my blood clot or to prevent bleeding. I have been told what a transfusion is and how it will be done.

I understand that there are risks associated with blood transfusions. These include (but are not limited to): Bruising, fever, chills, rash, hives or other allergic reactions, kidney failure, heart failure, shortness of breath, possible exposure to infectious disease such as hepatitis or HIV/AIDS, death.

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 products, the risks of not receiving the transfusion, the alternatives and the risks of the alternatives.

☐ I consent to the administration of all blood products including packed red blood cells, fresh frozen plasma, and platelets. I have been told about and acknowledge the risks and consequences of a transfusion and I want to receive any transfusions deemed medically necessary during my hospitalization or course of treatment.

☐ I refuse the administration of all blood products including packed red blood cells, fresh frozen plasma, and platelets.

☐ I refuse the administration of the following blood products:

Please specify: ____________________________________________________________

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

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.

Signature of patient or authorized representative: X ____________________________

Relationship: ___________________________ Time: ___________ Date: ___________

* If other than the patient, provide reason: ______________________________________

Signature of Witness (Age 18 or older, not the practitioner doing the procedure): X ____________________________

Title or relationship to patient: ___________________________ Time: ___________ Date: ___________

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 Signature: X ___________________________ ID#: ___________ Time: ___________ Date: ___________

Use of Interpreter or Special Assistance

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

_____ Foreign Language (Specify): ____________________________________________

_____ Sign Language

_____ Patient is blind, Consent form read to patient

_____ Other (specify): ______________________________________________________

Name of Interpreter: ___________________________ ID# ___________ Time: ___________ Date: ___________

Practitioner Signature: X ___________________________ ID# ___________ Time: ___________ Date: ___________

X