RM2C011

Stony Brook Medicine
Stony Brook, NY 11794

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: _____