DISCLOSURE AND CONSENT TO RECEIVE OR REFUSE BLOOD TRANSFUSION

Consent Other

TO THE PATIENT AND/OR LEGAL REPRESENTATIVE: Patients have the right to be informed about blood transfusions so that they may make the decision whether or not to undergo this transfusion after knowing the potential benefits, risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent.

I have been informed that _____ may need one or more transfusions, during this hospital admission or in the future. Such transfusions include red blood cells (carry oxygen) and/or other blood products such as platelets and plasma (help to clot blood), or white blood cells (fight infection).

I understand that the source of blood and/or blood products may be either (a) blood from donors or (b) my own blood that had been collected previously. I understand that it may not be possible to donate my own blood in advance due to such factors as my medical condition; or, if surgery is recommended, the date on which surgery is scheduled; or the amount required exceeds the number of units that I could donate in advance.

I understand that all blood and/or blood products are currently tested and screened for the presence of potentially transmissible infectious agents according to standards established by the Food and Drug Administration (FDA) and the American Association of Blood Banks (AABB). I also understand that the current screening of donated blood does not eliminate the potential transmission of every harmful infectious disease.

I understand that the transfusion of blood and/or blood products involves risks of allergic reaction, fever, hives, and in rare circumstances, infectious diseases such as hepatitis, HIV/AIDS and bacterial infections.

I have been given the opportunity to ask questions about this procedure and its risks and the risks of refusing. I have been informed and I understand that I am able to withdraw my consent and to refuse transfusion at any time, and that such withdrawal of consent may affect the outcome of my treatment or may change my treatment options.

PATIENT IDENTIFICATION

PRESBYTERIAN

PRINT FORM | SAVE FORM | RESET FORM

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CONSENT TO THE FOLLOWING: (Check only one)

☐ 1. To be transfused with blood and/or blood products from donors.

☐ 2. To be transfused with my own blood and/or blood products collected in advance to the fullest extent possible before using blood and/or blood products from any other source. I also consent to the use of blood, and/or blood products from any other source, depending on my medical condition and the availability of sufficient amounts of my own blood.

☐ 3. To be transfused with only the following components:

_____

☐ 4. I do not consent to the use of any blood products at any time.

I acknowledge by my signature below that this form has been fully explained to me, that I have read it or have had it read to me, that I understand its contents and that I have indicated my consent or refusal to consent above. I understand that my consent may be withdrawn at any time and that I am responsible for informing my physician(s) of such a change.

SIGNATURE OF PATIENT

SIGNATURE OF WITNESS

SIGNATURE OF OTHER LEGALLY RESPONSIBLE PERSON, IF PATIENT IS UNABLE TO SIGN

DATE 02/27/2009 TIME 8:30 am

RELATIONSHIP TO PATIENT

If applicable, this form has been translated to the patient/other legally responsible person by:

SIGNATURE OF TRANSLATOR

The risks, hazards, limitations and benefits, as well as alternative treatment possibilities have been reviewed with the patient.

PHYSICIAN (or PRACTITIONER) SIGNATURE
(or documentation by physician in the Progress Note)

PATIENT IDENTIFICATION

PRESBYTERIAN