

**Consent for Transfusion of Blood  
or Blood Components**

Patient's name: \_\_\_\_\_

**CONDITION:** You have a medical problem for which you are undergoing treatment. In the course of your treatment, it may become necessary or advisable to administer a transfusion of blood or blood components. This form provides basic information concerning this procedure and, if signed by you, authorizes the transfusion of blood or blood components.

**RIGHT TO RECEIVE INFORMATION AND TO CONSENT:** You have the right to receive information concerning your medical condition and any proposed transfusion. You also have the right either to consent to or refuse any transfusion of blood or blood components. Along with this consent form, you will receive a brochure, *A Patient's Guide to Blood Transfusions*. This brochure contains information concerning the benefits and risks of the various options for blood transfusions, including predonation by yourself or others. You should discuss with your physician any questions you may have about transfusions.

**RISKS:** All medical procedures carry some degree of risk, and transfusions are no exception. The risks of transfusions of blood or blood components include both minor and serious reactions to the blood or blood components, and complications resulting from the transfusion. There is also a risk of transmission of diseases such as hepatitis, the AIDS virus, or other blood transmittable diseases. All donated blood is carefully screened and matched, but there is no guarantee against these risks.

**ALTERNATIVES:** If loss of blood poses a serious threat in the course of your treatment, there is probably no effective alternative to blood transfusion. However, if you have any further questions on this matter, you should discuss them with your physician at this time.

**PREDONATION:** It may be possible to donate your own blood or to arrange for directed donations. This blood may not always be available or adequate for your transfusion needs. You have the right to have adequate time before your procedure to arrange for predonation, but you can waive this right if you do not wish to wait.

**CONSENT:** Your signature below indicates that: 1) you have received a copy of the brochure, *A Patient's Guide to Blood Transfusions*; 2) you have received information concerning the risks and benefits of blood transfusion and of any alternative therapies; 3) you have had the chance to discuss this matter with your physician, including predonation; and 4) subject to any special instructions listed below, you consent to such blood transfusions as your physician may order in connection with your treatment.

**SPECIAL INSTRUCTIONS:**  I wish to waive time for predonation.  I wish to predonate my own blood.

I wish to arrange for directed donations from family or friends.  Other: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Signature: \_\_\_\_\_  
PATIENT / PARENT / CONSERVATOR / GUARDIAN

If other than patient, indicate relationship: \_\_\_\_\_

Witness: Print name/title: \_\_\_\_\_ Signature: \_\_\_\_\_

**PHYSICIAN CONFIRMATION:**  Informed consent documented in:  H & P  Progress note  Pre-operative note

I have provided the patient with a copy of the state Department of Health Services information pamphlet, *A Patient's Guide to Blood Transfusions*, concerning the advantages, disadvantages, risks and benefits of autologous blood and of directed and non-directed homologous blood from volunteers. I have also allowed adequate time prior to surgery for the patient or other person to predonate blood for transfusion purposes, except where there is a life-threatening emergency, there are medical contraindications, or the patient has waived this right.

Predonation is ruled out because (complete):  Life-threatening emergency (specify): \_\_\_\_\_

Medical contraindications (specify): \_\_\_\_\_  Patient waived.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ MD Signature/ID#: \_\_\_\_\_

Telephone consent: MD name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness: Print name/title: \_\_\_\_\_ Signature: \_\_\_\_\_

**PATIENT'S REFUSAL TO PERMIT BLOOD TRANSFUSION**

I request that no blood components be administered to \_\_\_\_\_ during this hospitalization and I accept the risk of my refusal. I have received information concerning the risks and benefits of transfusions, including any alternative therapies. The possible risks and consequences of such refusal, which could include mental or physical incapacity, coma or even death, have been fully explained to me by my attending physician and I fully understand that such risks and consequences may occur as a result of my refusal. I have received a copy of the pamphlet *A Patient's Guide to Blood Transfusions*. I hereby release the hospital, its personnel, the attending physician and all other persons involved in my care from any responsibility or liability for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or blood components.

I will consent to the use of the following blood products: \_\_\_\_\_

\_\_\_\_\_  
(SIGNATURE OF PATIENT/PARENT/CONSERVATOR/GUARDIAN)\_\_\_\_\_  
(IF OTHER THAN PATIENT, INDICATE RELATIONSHIP)

MD: Signature/ID#: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness: Print name/title: \_\_\_\_\_ Signature: \_\_\_\_\_

Language Line Operator #: \_\_\_\_\_

Interpreter: Print name: \_\_\_\_\_ Signature: \_\_\_\_\_

Language: \_\_\_\_\_

 **Sign  
Here** **Sign  
Here**