Acceptance of Blood Products / Derivatives

Patient Diagnosis/Procedure: ____________________________

Valid for:

☐ Hospitalization
☐ Estimated dates of treatment: From __________ (date) to __________ (date)
☐ Outpatient: For duration of treatment starting __________ (date). Valid for duration of treatment, up to one year. New consent must be obtained if treatment is more than one year.

During your treatment, you may need transfusions of blood products and/or derivatives for the following reasons:

• Anemia (low red cell count), thrombocytopenia (low platelet count), and leukopenia (low white blood cell count) can occur as a result of your disorder and/or its treatment. Correction of anemia with red cell transfusions, correction of the thrombocytopenia with platelet transfusions, and correction of leukopenia with white blood cell transfusions may be necessary.

• Decreased blood factors can occur as a result of your disorder and/or its treatment. Replacement of these factors by transfusions of blood plasma products/derivatives may be necessary.

The risks of blood transfusions are as follows:

• Infections such as hepatitis and HIV (AIDS) which are very infrequent.

• Other complications such as transfusion reactions (fever, anxiety, chills, and discomfort) and changes in immunity may occur, especially if many transfusions are necessary.

I have read and understand the above information. My physician has explained the risks and benefits of blood transfusions and answered my questions. I agree to allow authorized members of the hospital staff to give me blood transfusions when deemed medically necessary.

Date Time Signature of Patient or Guardian Print Name

Refusal of Blood Products / Derivatives

The dangers of not proceeding with the recommended transfusion have been explained to me. Risks of not receiving a transfusion may include uncontrollable bleeding, anemia, organ failure, and death.

I personally assume the risks and consequences of refusal to consent to the transfusion(s), and I release all physicians who have been consulted in my case, the hospital and its staff from liability and damages for any ill effects which may result from not being transfused.

I do not consent to receive blood transfusions.

Date Time Signature of Patient or Guardian Print Name

Consent Form Witness:

Date Time Signature of Witness Print Name

I have discussed the treatment described above with the patient or relative whose signature appears on this document.

Person Explaining Procedure:

Date Time Signature/Title of Physician or Licensed Staff Explaining Procedure Print Name

CROSS OUT ANY OF THE ABOVE PARAGRAPHS WHICH DO NOT APPLY AND INITIAL