INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD COMPONENTS

I understand that my physician,_____has determined that I have or may develop a medical need to receive a transfusion of blood or blood products.

I understand that a blood transfusion may **benefit** me in one or more of the following ways:

1. Increased oxygen delivery to the brain and/or tissues;
2. Maintenance of blood pressure;
3. Prevention or reduction of abnormal bleeding due to clotting disorders;
4. Improvement of blood flow; and/or
5. Sustaining life.

I understand that if I have clotting disorders, transfusion of platelets, plasma and/or other blood products may prevent or reduce abnormal bleeding.

I understand that there are possible **risks** of receiving a transfusion, and that the risk of acquiring an infectious disease from transfused blood/blood products is low. Common risks may include, but are not limited to fever, rash, headache, and/or slight bruise or local reactions.

I understand that more serious **risks** are rare and may include, but are not limited to the following:

1. Serious allergic reactions;
2. Bacterial infections;
3. Viral infections (such as hepatitis or human immunodeficiency virus (HIV));
4. Lung injury with severe breathing difficulty; and/or
5. Death.

There are other options than getting blood or blood products, though they may not be as effective or show an effect for several days to a week. My doctor will discuss if the options are appropriate for my care. Other options include drugs which can decrease bleeding or drugs which cause my body to make more blood.

Acknowledgement

I have talked with my doctor about blood or blood component transfusion and the options listed above, and my doctor has answered my questions, if any. I fully understand this information, and if I have questions, I have had the opportunity to have them answered.

I understand that this consent is applicable for all transfusions during this admission (or within 30 days of signing this consent), but I may withdraw my consent at any time by notifying an RN or physician. If I am to receive multiple transfusions in an outpatient setting, I understand this consent is applicable for those transfusions unless I withdraw my consent by notifying my physician.

I have reviewed the above with my physician and:

- □ Consent to transfusion of blood products.
- □ I am currently undecided on transfusion of blood products.

REFUSAL OF BLOOD PRODUCT

By signing below, I confirm that I understand the possible consequences of **refusing** a transfusion may include serious injury, worsened or prolonged illness, and/or death.

- □ Decline transfusion of blood products.
- □ I withdraw my consent for transfusion of blood products.

Time	Date	PATIENT Signature (Parent/Guardian, if Minor, or person signing on patient's behalf)	Time	Date	Physician / PA / NP
			Time	Date	Physician Signature (if provided by NP/PA)
		RELATIONSHIP or authority if other than Patient	Time	Date	Witness
			Time	Date	Witness (if phone consent – 2 req'd)

820b

PT.

MR.#/P.M.

DR.