Consent/Refusal for Blood or Blood Products

Patient_____

Blood transfusions (and blood products such as plasma, platelets, or packed cells) are used to treat acute blood loss (from disease or surgery), acute and chronic anemia, and other conditions.

Use of such blood products involves some risks including reactions to the blood (allergic and other reactions), damage to the patient's own blood cells, and infections (including hepatitis and AIDS), among other possible risks.

There are no good alternatives to blood products to accomplish the purposes of carrying oxygen and providing the ability to clot. If there is enough time to prepare, a patient's own blood may be used, or blood may obtained from friends or relatives. At least three working days may be necessary to process blood from these sources; use of such alternative sources does not eliminate the risks listed above.

Please read this document carefully and indicate your consent to receive blood or blood products, or your refusal to receive blood or blood products.

If blood or a blood product is required and refused, risks may include organ damage form inadequate oxygen, such as heart attack or stroke, in some cases inability to control bleeding, and sometimes even death.

My physician has explained to me the reasons that blood product has been recommended for me. I have had an opportunity to ask questions about the risks of blood transfusion and the risks of refusal of blood transfusion.

Please initial one choice (consent or refusal) and sign below:

_____I **CONSENT** to transfusion

_____I **REFUSE** transfusion of blood or blood products recommended to me

Do not sign unless you have read and thoroughly understand this form.

Witness:_____

Patient/responsible party:_____

Date:_____

Physician declaration: I have explained the consents of this document to the patient and have answered all of the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

Physician's signature:_____   **Date**:_____

Health ONE ROSE Medical Center

Informed Consent Consent/Refusal for Blood or Blood Products
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Patient Information/Label

TREAT

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