

CONSENT FOR BLOOD/BLOOD PRODUCT TRANSFUSION

I, _____, hereby authorize the administration of blood/blood product transfusion and such additional transfusions to _____ under the direction of Dr. _____ the attending physician, or those he may designate to assist him for the duration of hospitalization and/or treatment of my medical condition.

I understand that transfusion of blood products may be necessary to maintain circulation to vital organs, and that impairment of circulation might lead to death. I understand that blood product, transfusions are not always successful in producing the desired results and there is a small possibility of ill effects such as the transmission of infectious diseases or reactions to the transfusions.

I acknowledge that I have been informed that some, but not all, of the potential risks for such blood transfusion and/ or blood products may include chills, fever, back pain, kidney problems, itching, rash, shortness of breath, palpitations, or headache. Transmission of diseases such as hepatitis, AIDS, and other infections, as well as fluid overload, is possible but very uncommon.

Possible alternatives, such as directed donations from friends or family members and the use of autologous blood has been discussed with me by my physician.

I acknowledge that my physician has explained to me the reasonable benefits proposed blood transfusion and/or blood products.

_____ I authorize the transfusion of blood/blood products as ordered by my physician or those he may designate to assist him. .

_____ I do not want blood or blood products administered under any circumstances.

DATE: _____

Signed: _____

(Patient or Authorized Person)

WITNESS: _____

(Relationship of authorized person to the patient)

Emergency situation requiring transfusion

YES

NO

(Physician Obtaining Consent)