

## Blood Product Information and Consent for Transfusion of Blood or Blood Products

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Your physician has advised you that transfusion of blood or blood products may be necessary. While many precautions are taken to make blood products safe, there are some well-known risks which are listed in No. 3 below.

1. I authorize the administration of blood or blood products transfused to and such additional transfusions as may be deemed advisable in the judgment of the attending physician or consultants.
2. I authorize the collection and administration and/or topical application of perioperative autologous blood products.
3. A physician has advised me of the reason for the transfusion and it has been fully explained that blood or blood product transfusions are not always successful in producing a desirable result. There is a possibility of ill effects, such as the transmission of blood transmissible diseases or blood impairments. I have been told, and I understand, that blood or blood products are supplied to the hospital by an FDA-licensed blood bank. The blood bank has tested the products for detectable blood transmissible diseases by currently acceptable procedures. I also understand that these procedures may not be infallible.

During the course of your treatment you may need to receive one or more blood products. The benefits of such an infusion are very individualized and are best explained by your physician. While many precautions are taken to make blood products safe, there are some well-known risks, including but not limited to, those briefly outlined below.

- a. **Transmission of infectious diseases:** Despite careful selection and testing of blood products prior to use, transmission of infectious diseases is possible. The present testing of blood greatly reduces the possibility of transmission of AIDS, viral hepatitis, or other rare infections.
- b. **Metabolic complications:** Massive blood infusions can lead to problems by causing changes in the body temperature or electrolyte balance.
- c. **Blood clotting problems:** Receiving large amounts of blood products may dilute out important elements that help the blood to clot. This can be prevented/treated by transfusing blood clotting elements when they are required.
- d. **Fever:** Transfused blood products can cause fever in some individuals.
- e. **Allergic reactions:** On occasion, a person may experience wheezing, itching, low-blood pressure, swelling in the throat, or breathing problems after blood transfusion.
- f. **Hemolytic reactions:** A potentially serious reaction can occur if you receive a unit of blood that is of a different type from your own.

Each of these complications is rare, but potentially life threatening. If you have any questions about these or other possible complications, please address them to your doctor.

I have read the above information and have been informed of the benefits and inherent risks associated with the transfusion of blood products.

4. I have had the opportunity to ask questions concerning the proposed transfusion of blood products, and my questions have been answered to my satisfaction.
5. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM  
PM

### When patient is a minor or incompetent to give consent:

\_\_\_\_\_  
(Signature of person authorized to consent for patient) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM  
PM

Relationship to Patient: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM  
PM

I refuse blood transfusions / blood products. I release the hospital, the doctor, and all other persons caring for me from all responsibility for any ill effects that may result from this refusal.

(Patient Signature) \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM  
PM

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM  
PM

PATIENT LABEL

**Consent for  
Transfusion  
of Blood or  
Blood Products**

D-14-89 (02-04-10)



\*CO0099\*

 **Hamot**  
Erie, Pennsylvania