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Options for Patients Objecting to Blood Transfusions

	Patient should check ✓ and initial each item	
	Accept	Refuse
Blood Components		
Red blood cells	☐ _____	☐ _____
Plasma (Frozen plasma)	☐ _____	☐ _____
Platelets	☐ _____	☐ _____
Cryoprecipitate	☐ _____	☐ _____
White Blood Cells	☐ _____	☐ _____
Blood Components		
Albumin	☐ _____	☐ _____
Plasma−Derived Clotting Factors (Fibrinogen, PCC, FEIBA)	☐ _____	☐ _____
Plasma−Derived Proteins (C1 esterase inhibitor)	☐ _____	☐ _____
Immune Globulins (IVIG, RhIg, Hepatitis B Ig, CMV Ig, etc)	☐ _____	☐ _____
Recombinant Blood Proteins		
Recombinant Clotting Factors (FVIII, FIX, FXIII, rFVIIa)	☐ _____	☐ _____
Specify other treatment:_____	☐ _____	☐ _____

Signature of Patient *(or Substitute Decision Maker)* | **Date** (dd/mm/yyyy)

Print Name of Patient *(or Substitute Decision Maker)* | **Relationship to Patient**

STATEMENT OF PHYSICIAN / HEALTH CARE PRACTITIONER

I confirm that I have explained the nature of the treatments(s), expected benefits, material risks, alternative courses of action as well as the likely consequences of not having the treatment to the above patient / substitute decision maker and answered all questions.

Signature of Physician/Health Care Practioner	Name of Physician/Health Care Practioner	Date (dd/mm/yyyy)

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Adapted from St. Michael's Hospital, Toronto; November 2015

CONS3b

Chart Copy − Do Not Destroy