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Consent or Refusal for Transfusion of Blood Components and/or Products

A copy of this form MUST be on the patients's chart

The physician or health care practitioner (Nurse Practitioner or Midwife) has fully explained to me:

- What is a blood transfusion
- The reason for the blood transfusion
- How the blood transfusion will benefit me
- What are the possible risks and side effects of a blood transfusion
- What may happen if I do not have a transfusion
- What other choices of treatment I have and their risks and side effects

I have had the opportunity to ask questions, which were answered to my satisfaction. ❑ Yes ❑ No Initials

TO BE COMPLETED BY PATIENT OR SUBSTITUTE DECISION MAKER

❑ I was given a copy of "Blood Transfusion − Information for Patient's Booklet"

❑ I ***AGREE*** to receive blood and / or products

❑ I ***AGREE*** to receive **ONLY** those blood components/products/procedures selected on the "OPTIONS FOR PATIENTS OBJECTING TO BLOOD TRANSFUSIONS" form (see form CONS3b)

_____ _____

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

_____

Print Name of Patient (or Substitute Decision Maker)

❑ I ***REFUSE*** to receive ***any*** blood component and / or products.

_____ _____

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

_____

Print Name of Patient (or Substitute Decision Maker)

TO BE COMPLETED BY PHYSICIAN / HEALTH CARE PRACTITIONER

I confirm that I have explained the nature of the treatments(s), expected benefits, material risks, alternative course 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 Print Name of Physician/Health Care Practioner Date (dd/mm/yyyy)

Transfusion Consent Type:

❑ Specific procedure or event (valid for specific procedure or event or duration of admission)

❑ Ongoing transfusion therapy − is part of the disease treatment plan (valid for duration of disease treatment in Outpatient Clinics Only)

Emergency Transfusion, no consent:

I certify that, due to the urgent need for transfusion, I am unable to obtain informed consent prior to therapy and that I have no advance directive indicating that transfusion in reasonable circumstances is rejected.

As mandated in the HEALTH CARE CONSENT ACT, Section 25.5, the Physician/Health Care Practitioner must promptly note on the patient's health record the opinions that are held by the practitioner on which he or she relied.

_____ _____ _____

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

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