BLOOD TRANSFUSION CONSENT / REFUSAL

• I have been given the Blood Transfusion Information for Patients sheet, and te risks and benefits have been explained to me.
• The blood/blood products transfusion process has been explained to me.
• I have had my questions about the transfusion of blood products answered.
• I understand that the decision I make about receiving blood products remains in place during this hospitalization and/or outpatient treatment for the same health problem for up to 1 year.
• I need to tell my doctor and sign a new consent form if I change my mind.
• I understand that whatever decision I make will not affect my right to receive medical care and treatment, now or in the future.

Based on the information provided, I have signed below, giving my consent or refusal for transfusion of blood or blood products (sign in one box only):

I CONSENT TO RECEIVE BLOOD or BLOOD PRODUCTS THROUGH TRANSFUSION if deemed necessary by my physician. The reason for the transfusion is:

❑ Replace lost blood components ❑ Increase oxygen carrying ability of your blood ❑ Correct bleeding disorders

_____ _____ _____
Patient signature or authorized representative/Relationship Date: Time:

I REFUSE AND DO NOT CONSENT TO RECEIVE BLOOD OR BLOOD PRODUCTS <u>except</u> those marked below and only if the doctor decides I need a transfusion to save my life or avoid permanent damage to tissues, organs or bodily functions.

In this emergency, I CONSENT TO RECEIVE the following:

❑ Red blood cell products
❑ Platelets
❑ Fresh frozen plasma
❑ Cryoprecipitate

_____ _____ _____
Patient signature or authorized representative/Relationship Date: Time:

I REFUSE AND DO NOT CONSENT TO RECEIVE BLOOD OR BLOOD PRODUCTS under any circumstances even if my doctor(s) decide a transfusion(s) are needed to save my life and/or avoid permanent damage to tissues, organs or bodily functions.

_____ _____ _____
Patient signature or authorized representative/Relationship Date: Time:

Provider Signature: _____ Date: _____ Time: _____

Interpreter Signature/Computer ID: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

Witness Name (Print): _____

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TRANSFUSION OF PACKED RED BLOOD CELLS & PLATELETS

ALL BLOOD PRODUCTS TO BE ADMINISTERED FOLLOWING ESTABLISHED POLICY & PROCEDURE

Patient Name: _____ Date of Birth: _____

PRBC'S 1 unit _____ 2 units _____ 3 units _____
SDU PLT: 1 unit _____ 2 units _____ 3 units _____
IRRADIATED: _____
NON-IRRADIATED: _____

EACH UNIT PRBC'S TO BE GIVEN OVER: 60 MIN _____
90 MIN _____

PRE-MEDICATION: TYLENOL 650 MG _____
BENADRYL PO 25 MG _____
50 MG _____
BENADRYL IV 25 MG _____
50 MG _____

AFTER 1ST UNIT GIVE: LASIX 20 MG IVP _____
AFTER 2ND UNIT GIVE: LASIX 20 MG IVP _____

LAB VALUES:
HGB _____
HCT _____
PLATELETS _____

TYPE AND CROSSMATCH: YES _____ NO _____

PRE-TRANSFUSION CBC: YES _____ NO _____

IF CBC TO BE DRAWN PRIOR TO TRANSFUSION, LIST PARAMETERS FOR TRANSFUSION:

_____

TRANSFUSION DIAGNOSIS: _____

STANDING ORDER: YES_____ NO_____ **IF YES, FREQUENCY:** _____

DATE _____ **PHYSCIAN SIGNATURE** _____

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