BLOOD TRANSFUSION

My doctor has informed me that during, or as a result of, the surgery I may need a transfusion of blood and/or blood products in the interest of my health and proper medical care. The blood/blood products that may be provided to me include:

- Autologous (blood donated by me for my own use)
- Designated (blood donated by others specifically for my use)
- Homologous (volunteer donor pool)

Patient’s Initials

I understand that when available, autologous and/or designated blood/blood products will be used first. These units will be reserved for me for a fixed and specified period of time only. In the event that such autologous and/or designated blood is insufficient for my transfusion needs, homologous blood/blood products from the hospital’s usual supply will be used.

I certify that my autologous blood unit(s) are available at: ___________________________

The details of having a blood transfusion including the anticipated benefits and material risks have been explained to me in terms I understand.

I further understand that I will not be informed of the identity of the donors whose blood/blood products are administered to me.

I understand and accept that the most likely material risks and complications of receiving homologous or designated transfusion(s) have been discussed with me and may include but are not limited to:

- mild allergic reactions
- hemolytic reaction
- possible exposure to infectious agents such as hepatitis, cytomegalovirus, infectious mononucleosis, and acquired immune deficiency syndrome (AIDS). These risks exist despite the careful testing of the blood and blood products

Alternative methods and therapies, their benefits, material risks and disadvantages, including the risks and consequences of not receiving therapy, have been explained to me.

The doctors has answered all of my questions regarding blood transfusions.

I certify that I have read and understand how blood transfusion might be used.

Patient or Legal Representative Signature/Date/Time __________________________ Relationship to Patient __________________________

Print Patient or Legal Representative Name Witness Signature/Date/Time __________________________

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives of blood transfusion to the patient or the patient’s legal representative. I have answered all questions, and I believe that the patient/legal representative (circle one) understands what I have explained.

Physician Signature/Date/Time __________________________

4/00
Revised 9/05, 12/05, 1/06, 3/08

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