UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

BLOOD TRANSFUSION CONSENT OR REFUSAL

Date: _____

Dr. / Licensed independent Practitioner (LIP) _____ has explained to me that I need or may need during treatment a transfusion of blood and/or one of its products for the following reason(s): _____

I understand in general what a blood transfusion is, the procedures that will be used, the benefits of receiving a transfusion and possible risks. These risks include, but are not limited to, hepatitis, allergic reactions, fever, transfusion-related acute lung injury, hemolysis, volume overload or rarely death. Other risks include exposure to the AIDS virus but that risk is very remote. I understand that these risks exist despite the fact that the blood has been carefully tested. No assurances or guarantees have been made to me about the outcome of the transfusion or the fitness or quality of the blood to be used.

Therefore —

☐ **Yes**, I **give** my informed and voluntary consent to the transfusion.

☐ **No,** I **do *not*** consent to the transfusion and understand the risks associated with this refusal may include permanent injury to me or possible death. I accept full responsibility for those risks.

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

_____	_____	_____	_____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	PRINTED NAME	**DATE**	**TIME**

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENT, CHECK RELATIONSHIP TO PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 7. Other Blood Relative
☐ 2. Guardian ☐ 5. Parent ☐ 8. Other* _____
☐ 3. Husband/Wife ☐ 6. Adult Brother/Sister

FOR MINOR PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement

*** Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.**

PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

_____	_____	_____	_____	_____
SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT	PRINTED NAME	PIC #	**DATE**	**TIME**

_____	_____	_____	_____
SIGNATURE OF WITNESS (OPTIONAL) **REQUIRED FOR TELEPHONE CONSENTS**	PRINTED NAME	**DATE**	**TIME**

E. INTERPRETER ATTESTATION:

Interpretation has been provided by:

_____	_____	_____	_____
SIGNATURE OF INTERPRETER/CYRACOM ID #	PRINTED NAME	**DATE**	**TIME**