

AU Health

USE OF BLOOD PRODUCTS

DOB: _____ EMRN: _____
ACCT #: _____ LOCATION: _____
* - - *

Patient's Printed Name _____

REFUSAL OF BLOOD PRODUCTS

I **DO NOT** want blood or blood products administered to me under any circumstances, even if in the medical opinion of my physician, my refusal to accept blood or blood products may seriously jeopardize my health or result in death. My physician has fully explained the risks to me and I understand and assume them.

CONSENT FOR BLOOD PRODUCTS

I **DO** authorize the administration of blood/blood product transfusion and such additional transfusions as directed by my physician for the duration of my hospitalization and/or treatment of my medical condition.

1. I understand in general what a transfusion is and the procedures that will be used. I understand that my physician will decide the amount and type of blood product(s) needed based on my particular needs to stabilize my condition or save my life.
2. **RISKS.** I acknowledge that I have discussed the risks of blood or blood product administration with my physician. I understand that there is a small but definite risk of potentially serious infectious disease transmission and / or other reactions. These diseases include, but are not limited to, hepatitis and acquired immune deficiency syndrome (AIDS). Other adverse reactions may include, but are not limited to, the symptoms of fever, chills, and hives or in more severe reactions, the possible destruction of the transfused red cells, isoimmunization, bacterial infections or rarely, death. I understand that steps are taken to safeguard the blood supply by taking blood from volunteer donors, questioning donors about their health history and risk factors, and extensive testing of the donor blood. I understand that no process or testing is 100% reliable. I acknowledge that no guarantees have been made to me about the outcome of the transfusion.
3. **BENEFITS.** The benefits and risks of transfusions, and the consequences of refusing to accept blood or blood products include seriously jeopardizing my health or resulting in death have been explained to me by my physician.
4. **ALTERNATIVES.** Alternatives to receiving blood or blood products have been explained to me by my physician. In the case of elective transfusion, alternatives from receiving blood from the community blood supply include the pre-donation of my own blood (autologous blood donation) or blood specifically designated for my use by my family and close friends (directed donations). Autologous donations should be collected at least 72 hours prior to surgery and directed donations require 5 days to process.

Consent to Blood Products

Refuse Blood Products

Patient (or Patient Representative) Signature

Date/Time

Patient

Parent

Guardian

Authorized Person (pursuant to O.C.G.A. §31-9-2)

The above **consent/refusal** is given on the patient's behalf because the patient is a minor (age: _____) or is unable to represent him/herself for the following reason: _____

Provider Signature

Provider's Printed Name

Date/Time

(See Page 2 for Telephone Consent) N/A



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TELEPHONE CONSENT (if applicable)

When a telephone consent is being obtained, the above information must be read to the person consenting.

I, _____, read the above information to _____ at **Date/Time:** _____.
(Name of Practitioner) (Name of Person Consenting)

_____ states that he/she is _____ of _____ and he/she
(Name of Person Consenting) (Relationship to Patient) (Name of Patient)

authorized the treatment/procedure described above and has been provided an opportunity to ask any desired questions.

Practitioner's Signature/ Title **Date/Time:** _____

I witnessed and overheard the telephone conversation in which the above consent was given to perform the desired treatment/procedure.

Signature of First Witness

Signature of Second Witness

Address: _____

Address: _____

