White Plains Hospital

# CONSENT FOR TRANSFUSION OF WHOLE BLOOD/BLOOD PRODUCTS

**Provide patient name and date of birth for faxing purposes**

*(Patient Sticker)*

**Patient Name:** ____________________

**Patient Date of Birth:** ____________________

1. My physician/provider ____________________ has fully explained to me the purpose of receiving one or more transfusions of whole blood or other blood components, including but not limited to red blood cells (carry oxygen from the lungs to all parts of the body, and carbon dioxide from the body to the lungs), plasma (liquid portion of the blood that contains water, protein, hormones and blood-clotting factors), platelets (aid in blood clotting and repairing injured blood vessels), and cryoprecipitate (substances that promote faster blood clotting).
2. I agree that my attending physician shall be responsible only for the performance of his own individual acts. The blood typing and the selection of compatible blood are the responsibility of the laboratory personnel who perform the necessary laboratory tests.
3. I understand that emergencies may arise where it may not be possible to perform tests for cross-matching my blood and that my immediate needs may make it necessary to use existing stocks of blood that offer the least incompatible blood types.
4. I understand that some blood products may carry a risk for infectious agents, including but not limited to infectious hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and other diseases, despite appropriate and reasonable screening. I further understand that some blood products are manufactured from the pooled blood of many donors, thus increasing the risk of infectious disease transmission.
5. I recognize and understand that there are always risks to life and health associated with blood transfusions, both during the transfusion and thereafter. Such risks, benefits and alternatives, and the risks of the alternatives including no treatment, have been fully explained to me. The risks discussed include, but are not limited to:
   - Allergic reaction to the transfusion products including itching, hives, wheezing and chills, fever, and anaphylactic shock (allergic reaction that involves the entire body and can cause difficulty breathing) or even death.
   - Non-hemolytic reaction to the transfusion which results in fever and chills but does not destroy the red blood cells.
   - Hemolytic reaction to the transfusion which can destroy red blood cells, platelets or even injure the lungs.
   - Fluid overload, which may require the use of medications known as diuretics to decrease the fluid volume in the bloodstream.
   - Hemochromatosis (iron overload)
   - Viral or bacterial infection including but not limited to AIDS and hepatitis.
6. The alternatives discussed include but are not limited to the use of volume expanders (solutions that increase the fluid volume in the bloodstream, hematinics (medications that improve the red blood cell count and/or iron level of the blood), preoperative deposits of my own blood, and blood salvaging either during or after surgery, with later use of the preserved blood (Perioperative Autologous Transfusion, Cell Saver). The risks of the alternatives have also been explained to me.
7. The administration of whole blood or other blood components is not always successful in producing a desirable result. I acknowledge that no guarantees or assurances have been made to me concerning the results of the transfusion.

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8. I understand and expressly agree that the Hospital has made no guarantees or assurances about the fitness or quality of the blood supplied. I further expressly agree to release the Hospital, its personnel, employees, agents, and Medical Staff from all responsibility or liability for the consequences, if any, resulting from the administration of blood, plasma or other blood components.

9. I consent to the administration of blood transfusions and/or other blood components in such amounts and at such times as may be deemed advisable in the judgment of my attending physician.

10. I have been given an opportunity to ask questions. All of my questions have been answered to my satisfaction.

11. I confirm that I have read and fully understand the above I have crossed out and initialed any paragraphs or words above that do not pertain to me.

| ________ | ____/____/______ | ______________________ | ______________________ | ______________________ |
|---|---|---|---|---|
| **TIME** | **DATE** | ***(Patient/Health Care Agent/Surrogate/ Guardian Printed Name)** | **(Signature)** | **(Relationship to Patient)** |

| ________ | ____/____/______ | ______________________ | ______________________ |
|---|---|---|---|
| **TIME** | **DATE** | **(Witness Printed Name)** | **(Signature)** |

☐ Mark this box if telephone consent ☐ Mark this box if interpreter was involved. ______________________

Interpreter ID #

*The signature of the patient must be obtained unless the patient is a minor (under the age of 18), or is unable to give consent or otherwise lacks capacity to consent. Reason: ______________________

**Physician Attestation:**

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives (including no treatment and the attendant risks) to the proposed operation(s)/ procedure(s) and/or courses of treatment. I have offered to answer any questions and have fully answered all such questions. I believe that the Patient/Health Care Agent/ Surrogate/Guardian fully understands what was explained and answered.

| ________ | ____/____/______ | ______________________ | ______________________ |
|---|---|---|---|
| **TIME** | **DATE** | **(Physician's/Provider's Printed Name)** | **(Signature)** |

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