White Plains Hospital

Provide patient name and date of birth for faxing purposes

(Patient Sticker)

Patient Name: ______________________________

Patient Date of Birth: ______________________________

REFUSAL TO PERMIT BLOOD TRANSFUSION

1. I request that no blood or blood products be administered to me/the patient during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending physician to preserve my/the patient's life or promote recovery.
2. I hereby release the Hospital, its personnel, and the attending physician/provider from any responsibility whatever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives.
3. My physician/provider has discussed with me/the patient the risks of refusing transfusion(s), including but not limited to: heart arrhythmia (abnormal heart beat), shortness of breath, shock, continued bleeding, death, brain damage, paralysis, increased likelihood injury to the heart and lungs, paralysis and other foreseen and unforeseen consequences. The alternatives to transfusion of whole blood, and or blood products, and the attendant risks of those alternatives, have been explained to me.
4. I fully understand the need for this treatment and the possible consequences of such refusal on my part.
5. I have been given an opportunity to ask questions. All of my questions have been answered to my satisfaction.
6. I confirm that I have read and fully understand the above. I have crossed out and initialed any paragraphs or words 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 procedure. 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)

WREFUSETRANSF