

CONSENT TO TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

Date: _____

Time: _____

I understand that my treatment at McLaren Flint may involve the transfusion of blood or blood cell products. The blood or blood product used is obtained in conformity with policies of the American Red Cross to ensure quality and safety of the product. However, transfusion does carry some risks. Non-serious reactions could include headache, chills, fever or skin irritation or infection at site of transfusion. Serious reactions are very unlikely, but include transmittable diseases such as viral hepatitis, or other blood-borne diseases. Finally, despite careful testing and handling, there is a slight possibility of transfusion reaction.

Transfusion will only be used if my doctor believes it is in my best interest. I have been provided with information regarding alternatives to the administration of blood products. My decision (below) to consent to a transfusion also indicates my acceptance of the risks associated with transfusion, with recognition of those risks.

NO I am **refusing** to consent to receive blood or blood products.

I understand that this refusal could put my life in jeopardy. I release McLaren Flint, its personnel and the physician(s) from any responsibility for any or all unfavorable reactions or untoward results due to my refusal to permit the use of blood or blood products.

Signature of Patient: _____

If patient is unable to sign or is a minor, complete the following: Patient is _____ years old **OR**

Patient is unable to sign because _____

(Witness)

(Closest Relative or Legal Guardian)

YES I am giving consent to receive:

- Regular blood or blood products from the Blood Bank
- Autologous donations (self-donations only)
- Designated (directed) donations only

I understand the content and significance of this form; and my questions regarding risks, benefits and alternative treatments have been answered.

Signature of Patient: _____

If patient is unable to sign or is a minor, complete the following: Patient is _____ years old **OR**

patient is unable to sign because _____

(Witness)

(Closest Relative or Legal Guardian)

