

## McLaren Print System Order

Order No: 50250  
 Order Date: 2019-11-12  
 User: Robin Lutz  
 Phone: 342-2616

Ship Location: 9 south McLaren Flint Attn: Robin  
 401 S. Ballenger Hwy.  
 Flint, MI 48433

Forms  
 Quantity: 100  
 Paragon Dept No: 20410  
 Dept Name: PCU  
 Company Number: 60

Order Total Price: 3.60

Item Number: 17289  
 Item Description: Consent to Transfusion of Blood or Blood Products  
 Revision Date: 3/2019  
 Print: 1 sided black and white  
 Paper: 20# White Text  
 Size: 8.5 x 11  
 Fold:  
 Finish:  
 Drill: 5 Hole Top  
 Misc Info:

McLaren Health Care

**INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD COMPONENTS**

I understand that my physician, \_\_\_\_\_, has determined that I have or may develop a medical need to receive a transfusion of blood or blood products.

I understand that a blood transfusion may benefit me in one or more of the following ways:

1. Increased oxygen delivery to the brain and/or tissues.
2. Maintenance of blood pressure.
3. Prevention or reduction of abnormal bleeding due to clotting disorders.
4. Improvement of blood flow, and/or
5. Saving my life.

I understand that if I have clotting disorders, transfusion of platelets, plasma and/or other blood products may prevent or reduce abnormal bleeding.

I understand that there are possible risks of receiving a transfusion, and that the risk of acquiring an infectious disease from transfused blood/blood products is low. Common risks may include, but are not limited to fever, rash, headache, and/or slight bruise or local reactions.

I understand that more serious risks are rare and may include, but are not limited to the following:

1. Serious allergic reactions.
2. Bacterial infections.
3. Viral infections (such as hepatitis or human immunodeficiency virus (HIV)).
4. Lung injury with severe breathing difficulty, and/or
5. Death.

There are other options than getting blood or blood products, though they may not be as effective or show an effect for several days to a week. My doctor will discuss if the options are appropriate for my care. Other options include drugs which can decrease bleeding or drugs which cause my body to make more blood.

**Subsidiary Consent**

I have talked with my doctor about blood or blood component transfusion and the options listed above, and my doctor has answered my questions, if any. I fully understand this information, and if I have questions, I have had the opportunity to have them answered.

I understand that this consent is applicable for all transfusions during this admission (or within 30 days of signing this consent), but I may withdraw my consent at any time by notifying an RN or physician. If I am to receive multiple transfusions in an outpatient setting, I understand this consent is applicable for those transfusions unless I withdraw my consent by notifying my physician.

I have reviewed the above with my physician and:

- Consent to transfusion of blood products.
- I am currently undecided on transfusion of blood products.

**REFUSAL OF BLOOD PRODUCT**

By signing below, I confirm that I understand the possible consequences of refusing a transfusion may include serious injury, worsened or prolonged illness, and/or death.

- Decline transfusion of blood products.
- I withdraw my consent for transfusion of blood products.

<p>Time _____ Date _____ <b>PATIENT Signature (Parent/Guardian, if Minor, or person signing on patient's behalf)</b></p> <p>RELATIONSHIP to authority if other than Patient _____</p>	<p>Time _____ Date _____ <b>Physician (M.D./NP)</b></p> <p>Time _____ Date _____ <b>Physician Signature (if provided by NP/PA)</b></p> <p>Time _____ Date _____ <b>Witness</b></p> <p>Time _____ Date _____ <b>Witness of phone consent -- (if applicable)</b></p>
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8200

Spec Info: