Adventist Health Tillamook

Consent/Refusal for the Transfusion of Blood and/or Blood Products

Patient: _____

1. **Procedure/Reason (do not use abbreviations):** It has been explained to me that I need, or may need, a blood transfusion(s) or the administration of blood products for the following reasons. _____

   _____

   I understand that my physician will decide the amount and type of blood product 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, hives, or in more severe reactions, the possible destruction of the transfused red cells, isoimmunizations, 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, as well as the risks, benefits and side effects associated with these alternatives. In the case of elective transfusion, alternatives from the community blood supply include 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.

5. **Patient's consent:** I have read and fully understand this consent form. I understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction, or if I do not understand any of the terms or words contained in this consent form.

   If you have any questions regarding the risks, benefits, alternatives or methods of the proposed blood transfusion, ask your physician before signing this consent form. Do not sign unless you have read and thoroughly understand this form.

Patient/Patient representative signature	Patient/Patient representative printed name	Date	Time
Witness signature	Witness printed name	Date	Time

I DO NOT CONSENT to the transfusion of blood and/or blood products, and the risks associated to my refusal have been fully explained to me. I hereby release Adventist Health Tillamook and its employees, together with all my physicians, from liability for respecting and following my expressed wishes and directions.

Patient/Patient representative signature	Patient/Patient representative printed name	Date	Time
Witness signature	Witness printed name	Date	Time

6. **Physician declaration:** I have explained to the patient/patient's representative the risks, benefits and alternative (including the probable or likely consequences if no treatment is pursued). I have answered all of the patient's questions and to the best of my knowledge, I believe the patient has been adequately informed.

Physician signature	Physician printed name	Date	Time

Consent for Authorization of Blood

Consent/Authorization for the Transfusion of Blood
Adventist Health Tillamook
1000 Third St., Tillamook OR 97141

{ Patient Label }