



SPARTANBURG
Regional Healthcare System

SRMC SHRC VH

**BLOOD/BLOOD PRODUCTS
RELEASE OF LIABILITY FORM**

To the Spartanburg Regional Healthcare System and the medical and nursing personnel providing medical treatment to the following patient:

Print Patient's Name

Date

Instruction for Completion: Please choose the category that applies and select the appropriate alternatives in the box. If you need assistance in choosing alternatives in the box, please contact the Blood Bank.

CATEGORY ONE

You are hereby notified and instructed that **I DO NOT WISH any transfusion** of whole blood, red blood cells, white blood cells, platelets or plasma to be used in my medical treatment, and I understand the risks and benefits, which have been explained to me.

CATEGORY TWO

You are hereby notified and instructed that I wish to **reduce my exposure to blood transfusion**. I request that methods be employed to conserve and maximize my own blood supply (if determined clinically necessary). I understand that this approach to patient care will reduce, but may not completely eliminate the need for blood therapy at some future point in my medical care.

The following are methods I will accept in my treatment to reduce any need for blood transfusions:

(for either category 1 or category 2)

Please initial:

<input type="checkbox"/> Hemodilution	<input type="checkbox"/> Autologous Platelet Gel
<input type="checkbox"/> Interoperative/post operative blood salvage	<input type="checkbox"/> Vitamins/iron to build up my own blood
<input type="checkbox"/> Dialysis / heart-lung equipment	<input type="checkbox"/> Medications to control bleeding
<input type="checkbox"/> Albumin (minor blood fraction)	<input type="checkbox"/> Using small tubes to collect blood samples
<input type="checkbox"/> Erythropoietin (contains albumin)	<input type="checkbox"/> Non-blood volume expanders
<input type="checkbox"/> Clotting factors (minor blood fraction) (fibrinogen, Factors VII, VIII, IX and XII)	<input type="checkbox"/> Cryoprecipitate (use of this product will require a blood bank number)
<input type="checkbox"/> Immunoglobulins (minor blood fraction) (Rh immune globulin, gamma globulin, etc.)	<input type="checkbox"/> Other _____

I understand that by refusing to consent to blood transfusions and/or by reducing my exposure to blood transfusions/blood products, I am taking certain risks, but that I am willing to accept those risks, including the risk that I might die if I do not get a blood transfusion. I have talked with my treating physician _____ and/or nurse _____ or the Bloodless Coordinator _____ about my condition and about my need for a transfusion and/or blood products. We discussed different ways to do transfusions, the risks, benefits and complications of transfusions and I understand what we talked about. I am willing to accept those risks. I have read this form or have had it read to me. I understand what it says and I understand why I am signing it. This decision is mine and I have received what I consider to be proper and sufficient information to enable me to make this decision.

Patient / Authorized Surrogate Decision Maker Signature Date

Witness Signature Date

Patient / Designee / Proxy Signature **(PRINT NAME)**

Witness Signature **(PRINT NAME)** Date

Patient Label