SPARTANBURG
REGIONAL HEALTHCARE SYSTEM ☐ SMC ☐SHRC ☐PMC ☐UMC

CONSENT OR REFUSAL FOR BLOOD/BLOOD COMPONENTS TRANSFUSION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Administration of Blood or Blood Components *(consent signature must be complete)*

The following are some of the possible **benefits** of transfusion:
- Restores blood and oxygen carrying capacity lost through bleeding or due to anemia
- Prevent serious illness or death due to blood loss
- Blood components, i.e., fresh frozen plasma, platelets, cryoprecipitate, may help to restore normal blood clotting.

The following are some, but not all, of the potential **risks** that I am told can occur:
- Fever and allergic reactions
- Hemolytic transfusion reactions
- Bacterial septic reaction
- Transmission of diseases such as Hepatitis B, Hepatitis C, HIV (AIDS), and cytomegalovirus (CMV)
- Transfusion related acute lung injury
- Fluid overload

******SELECT AND SIGN ONLY ONE BOX ******

Signature indicates I received copy of educational material

BLOOD TRANSFUSION CONSENT

I GIVE MY CONSENT to the administration of blood or blood components should the need arise during my course of treatment. Further, I understand that despite careful testing and screening of blood and blood components by collecting agencies, I may still be subject to ill effects as a result of receiving a blood transfusion and/or blood components. Blood and blood components may include packed red cells, platelets, plasma, cryoprecipitate and/or plasma derivatives.

_____
Patient/Patient Representative Signature

_____
Relationship

_____ _____
Date Time

_____
Physician/NP/PA Signature

_____ _____
Date Time

_____
Witness to Signature

_____ _____
Date Time

_____
Interpreter

_____ _____
Date Time

LIMITED CONSENT/BLOOD CONSERVATION

I GIVE MY CONSENT to the administration of the following specific fraction(s)/components and/or blood conservation techniques as listed below:

Patient to Initial

Blood Components	**Accept**	**Refuse**
Red Blood Cells		
Platelets		
Plasma		
Albumin		
Cryoprecipitate		
Erythropoietin		
Immune Globulins		
Clotting Factors		
Blood Conservation	**Accept**	**Refuse**
Cell Salvage		
Hemodilution		
Autologous Platelet Gel		

_____
Patient's/Patient Representative's Signature

_____
Relationship

_____ _____
Date Time

_____
Physician/NP/PA Signature

_____ _____
Date Time

_____
Witness to Signature

_____ _____
Date Time

_____
Interpreter

_____ _____
Date Time

BLOOD TRANSFUSION <u>REFUSAL</u>

I REFUSE all blood and blood components. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

_____
Patient/Patient Representative Signature

_____
Relationship

_____ _____
Date Time

_____
Physician/NP/PA Signature

_____ _____
Date Time

_____
Witness to Signature

_____ _____
Date Time

_____
Interpreter

_____ _____
Date Time

Patient Label