Bethesda Hospital East
2815 S. Seacrest Blvd
Boynton Beach,FL 33435
(561) 737-7733

Bethesda Hospital West
9655 Boynton Beach Blvd,
Boynton Beach, FL 33472
(561) 336-7000

CONSENT FOR TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

PATIENT:

I here by authorize Doctor(s) to perform upon the following procedure or operation:

In the course of your treatment, your physician has determined that it is necessary to administer a transfusion of blood or blood products. This form provides basic information concerning this procedure, and if signed by you, authorizes its performance by qualified medical personnel.

DESCRIPTION OF PROCEDURE
Blood is introduced into one of your veins, commonly in the arm, using a sterilized disposable needle. The amount of blood transfused and whether the transfusion will be of blood, blood components or blood products, such as plasma, is a judgment the physician will make based on your particular needs.

RISKS

• A transfusion is a common procedure of low risk.
• Minor and temporary reactions are not uncommon, including bruising, or local reaction in the area where the needle pierces your skin or a non serious reaction to the transfused material itself, including headache, fever or mild reaction such as skin rash.
• A serious reaction is possible, but unlikely since all blood is carefully matched prior to transfusion, except in life-threatening emergencies.
• Infectious diseases, which are known to be transmittable by blood, include Transfusion Associated Viral Hepatitis (TAVH), a viral infection of the liver and Acquired Immunodeficiency Syndrome (AIDS). The risk of acquiring an Infectious Disease from transfused blood is relatively low and blood units are tested to avoid TAVH and HIV as required by state and feral standards. However, these laboratory tests are not foolproof.

BENEFITS/ALTERNATIVES

• The loss of blood can pose serious threats during the course of treatment for which there is no effective alternative to blood transfusion. If you have any further questions on this matter, your physician or his/her colleagues will explain the alternatives to you if this has not already been done.

STATEMENT OF REFUSAL

I request that no blood or blood component be administered to me during the course of this hospitalization. I hereby release my physician(s), the hospital and its personnel from any responsibility whatsoever for unfavorable reactions, untoward results or death due to my refusal to permit the use of blood or blood components. The possible consequences of such refusal on my part have been fully explained to me by a physician and I fully understand that such consequences may occur as a result of my refusal.

I UNDERSTAND that no guarantees have been made to me that this operation will improve my condition.

(PATIENT SIGNATURE) _____ Date:_____ Time:____

Patient is unable to sign because:

(If patient unable to sign, person authorized to sign.) _____ Date:_____ Time:___

(Witness to Signature or Telephone Consent Only) _____ Date:_____ Time:___

(Second Witness to Telephone Consent Only) _____ Date:_____ Time:___

Interpreted By:

(Interpreted By) _____ Date:_____ Time:____

FORM:	**Blood Transfusion Consent Form**	**MRIN#:**	
PATIENT:		**DOB:**	
PATIENT#:		**AGE:**	
GENDER:		**DATE:**	
ADMIT DATE:		**TIME:**	