

# CLEMENTI HOSPITAL

LEE HO YIN  
S4897583E  
Blk 648, Clementi Ave 4,  
#03-723 S 650648

## CONSENT FOR TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

ACCOUNT NO  
NRIC NO.  
NAME  
ADDRESS  
SEX/BIRTH DATE/RACE  
DATE AND TIME OF ADMISSION

Part I - To Be Filled By Patient

\*My / the patient's doctor Johnny Tay Tim Huat has advised me that due to \*my / the patient's medical condition, \*I / the patient need or may need transfusion of \*autologous blood / blood and/or blood products (that include packed red blood cells, fresh frozen plasma, platelets or cryoprecipitate).

I fully understand the procedure of transfusion that has been explained to me. It was also explained to me the alternatives to blood transfusion and/or blood products including the consequences if the transfusion is not given.

The doctor has explained to me the possible risks involved with this blood transfusion including, but not limited to infectious hepatitis, acquired immune deficiency syndrome (AIDS), or certain other diseases, unexpected blood reactions such as allergic reactions, itching and fever (for transfusion of non-autologous blood).

The table below shows the potential risks of blood transfusion that might occur :  
(Reference : AuBuchon JP & Kruskal MS et al, Transfusion : Realigning Efforts with Risks, Transfusion 1997; 1211 - 1216)

RISKS	FREQUENCY PER MILLION UNITS TRANSFUSION	PERCENTAGE
Urticarial Reaction	10,000 - 20,000	1 - 2
Febrile Reaction	5,000 - 10,000	0.5 - 1
Hepatitis B	16	0.0016
Hepatitis C	10	0.001
Haemolytic Reaction	1.7	0.00017
HIV Transmission	1.5	0.00015

I accept all the risks explained and hereby I authorise the administration of \*autologous blood or blood and/or blood products to \*me / the patient in connection with \*my / the patient's medical care as may be deemed advisable in the judgement of the doctor.

I agree that this informed consent may serve for consent to give additional necessary blood products at various times up to the end of this hospitalisation or for the complete course of this illness.

Lee Ho Yin  
(\*Name of \*Patient / Parent / Guardian / Legal Representative)

[Signature]  
(\*Signature / Thumbprint / Right / Left of \*Patient / Parent / Guardian / Legal Representative)

(Date of Signing)

Reason patient cannot sign : NA

G-2009-02-006 (DEC 04)

\* Please delete accordingly

(To be continued on the next page)

ID: 878792301

Witnessed by: Maicy Tan  
(Name of Witness)

MR  
(Signature of Witness)

Part II - To Be Filled By Medical Practitioner

I confirm that I have explained the risks, benefits and alternatives of this blood transfusion to the patient / patient's parent / guardian / legal representative and the above named witness.

MR 06064B  
(Signature of Medical Practitioner)

(Date of Signing)

Part III - To Be Filled By Interpreter (If Applicable)

I, \_\_\_\_\_ confirm that I have explained to the patient / patient's  
(Name of Interpreter)  
parent / guardian / legal representative the nature, effect and purpose of the blood transfusion in  
(Language / Dialect)

NA

(Signature of Interpreter)

(Date of Signing)

Please delete accordingly