



**Patient name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Procedure/reason:** \_\_\_\_\_

I (patient or guardian) hereby authorize (provider) \_\_\_\_\_ or his/her designee and such other providers, or other persons that are needed to assist him/her to perform: blood transfusion(s). I understand the transfusion procedure. I understand that my provider will decide the amount and type of blood product needed based on my particular needs to stabilize my condition or save my life.

**Alternatives:**

Alternatives to receiving blood have been explained to me by my provider. In the case of elective transfusion, I may include the pre-donation of my own blood. Autologous donations will be collected at least 72 hours prior to any procedure.

**Risks:**

I acknowledge that I have discussed the risks of blood transfusion with my provider. I understand that there is a small but definite risk of potentially serious infectious disease transmission and/or other reactions. These reactions include:

- Minor and temporary reactions and include, slight bruising, swelling or location reaction in the area where the needle pierces the skin, or a reaction to the transfused material itself, including headache, fever or allergic reaction. If red cells are transfused a serious reaction is possible, but very unlikely, since all blood is carefully matched prior to transfusion
- Infectious diseases which are known to be transmittable by blood include: hepatitis, HIV infection and cytomegalovirus (CMV) I understand that steps are taken to safeguard the blood supply. I acknowledge that no guarantees have been made to me about the outcome of the transfusion.

**Benefits:** The benefits and risks of transfusion and the consequences of refusing to accept blood or blood products that may include seriously jeopardizing my health or resulting death have been explained to me by my provider.

**Patient's consent:**

I have read and fully understand this consent form. I understand that 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. I understand that I can withdraw this consent to the procedure at any time before the beginning of the procedure.

\_\_\_\_\_  
 Patient/Guardian (state relationship)      date/time      Witness signature      date/time

**Refuse to permit blood transfusion**  
 I \_\_\_\_\_ request that no blood or blood derivatives be administered to me during this hospitalization. I hereby release Garfield County Hospital District, it's personnel and the attending provider from any responsibility for unfavorable reactions or by untoward results due to my refusal to permit the use of blood or blood derivatives and I fully understand the possible consequence of such refusal on my part.

**Provider declaration:**

I have explained to the patient/patient's guardian the procedure and the risks, benefits, and alternatives (including the probable or likely consequences if no treatment is pursued). I have answered all the patient's questions and to the best of my knowledge I believe the patient has been adequately informed.

\_\_\_\_\_  
 Provider signature      date/time

\_\_\_\_\_  
 Patient signature      date/time      Parent/Guardian      date/time

\_\_\_\_\_  
 Witness      Relationship      date/time