EMORY HEALTHCARE

Consent to Administration of Blood or Blood Products

Date:_____/_____/_____ Time: _____

The use of blood and blood products to treat my condition has been explained to me and I have been given the chance to ask questions.

I understand that Emory Healthcare and all suppliers from which it gets blood or blood products follow required safeguards, steps, and standards of the American Association of Blood Banks (AABB) and/or the Food and Drug Administration (FDA) in choosing donors and in collecting, handling, storing, keeping, and giving blood and blood products. In accordance with these standards, the blood screening process will include testing for the hepatitis virus and the human immunodeficiency virus ("HIV", the virus that causes AIDS), but does not include testing for all types of other diseases. I realize that no screening process or testing is 100% reliable in finding all types of viruses and other diseases. I further understand that in an emergency, giving blood or blood products to me may be needed before all tests have been done.

I understand there are no artificial or natural substances that can perform all functions of blood. I realize getting blood can be used to maintain or improve transport of oxygen, to improve clotting, to exchange for blood that has been removed, and to meet other needs. Most of the time, the use of blood from random donors is needed. Yet, in some cases it may be possible to use one of these: blood from donors I select; blood obtained from me before or during surgery; non-blood maintenance fluids; or a shot to help correct anemia. These options have been discussed with me and are described in the Blood Transfusion pamphlet that I can request to review.

I realize that, despite all steps referred to above, there are risks and adverse effects that may occur from getting blood or blood products from random donors, from donors I select, or obtained from me, or from fluids to replace volume. These possible adverse effects include, but are not limited to, severe risks (germs such as hepatitis virus, HIV, and bacteria that can cause sepsis; lung damage; blood clots; death), and less severe but still major risks (fever; allergic reactions including wheezing, facial swelling, rash, itching; nausea/vomiting; feeling short of breath; too much iron; headache; back and chest pain; changes in blood pressure).

I also realize that if I do not receive blood or blood products to treat my condition, I could suffer serious health consequences, including severe illness or death. If I refuse blood or blood products, I will be asked to sign a separate form on page two, showing that I accept that decision and its possible consequences.

FOR REFUSAL: Do **NOT** sign below. Complete and sign your **REFUSAL** of blood/blood product transfusion on page two.

Based on the above, **I hereby consent to receive the blood and/or blood products recommended for me**. If my medical condition requires getting blood and/or blood products on a frequent basis, I hereby consent to getting blood and blood products on that basis. I have been informed in general terms of the following information about getting blood and/or blood products:

(1) My health status, prognosis, and diagnosis;
(2) The nature and purpose of the procedure(s), including potential anticipated benefits;
(3) The risks;
(4) The chance of reaching goals and success;
(5) The practical, reasonable alternative options, if there are any;
(6) The prognosis if I do not get the blood or blood product(s);
(7) The relevant risks, benefits, and side effects of the options, including the possible effects of declining blood or blood products;
(8) Potential problems that might occur while I recover

By signing below, I hereby acknowledge and agree that I have read this form or it has been read to me. I understand its terms and I have been given the chance to ask questions, which have been answered. I understand the risks and benefits or getting blood and/or blood products as they were explained to me, and as described above, and I agree to receive blood and/or blood products.

I REQUEST AND CONSENT TO THE ADMINISTRATION OF BLOOD AND/OR BLOOD PRODUCTS AS OUTLINED ABOVE.

_____	_____	_____	_____
Signature of Patient/Authorized Representative	Date	Time	If not patient, relationship to patient

Printed Name of Patient/Authorized Representative (print):_____

❑ Check if telephone consent given

Witness to Signature:_____ Date: _____ Time: _____
(Witness signature required only for telephone consents)

Interpreter Name/Operator Number:_____

Signature of Person Obtaining Consent:_____ Date: _____ Time: _____

EMORY HEALTHCARE

Refusal of Blood and Blood Products or Consent to only Limited Blood or Blood Products

Date:_____/_____/_____ Time: _____

SECTION A: REFUSAL OF BLOOD TRANSFUSION OR CONSENT TO ONLY LIMITED BLOOD PRODUCT TRANSFUSIONS AT EMORY HEALTHCARE.

I realize that I need or may need to receive blood, blood products, or both as advised by my doctor. I understand the risks and benefits of getting blood or blood products. I am choosing to **refuse** getting some or all blood products as noted below. I understand that if I refuse some or all blood or blood products, I am acting against medical advice, and the risks to me include but are not limited to: severe risks (heart failure, organ failure, severe bleeding, death), less severe but still major risks (chest pain, shortness of breath, fatigue, weakness, feeling dizzy or irritable, headache), and other risks as explained to me by my provider (_____). In addition to severe illness or death to myself, if I am pregnant I realize my refusal could cause the death of my unborn baby. I have had the chance to read the Blood Transfusion pamphlet and/or to ask my healthcare providers questions about getting blood and blood products, and other possible options. All of my questions have been answered by my healthcare provider. Understanding all of the above, and despite my physician's advice, I am freely choosing to either **REFUSE ALL** blood and blood products **(Option 1)**, or **TO ACCEPT ONLY CERTAIN** products that I have checked below **(Option 2)**.

INITIAL ONLY ONE OF THE TWO OPTIONS BELOW:

Initial: _____ **Option 1:** By signing below, I hereby decline and DO NOT CONSENT TO RECEIVE ANY OF THE BLOOD OR BLOOD PRODUCTS LISTED IN SECTION B BELOW. By choosing not to receive blood or blood products if they are needed, I realize the risks to me could include added medical problems, complications of current medical problems, major injury, or death, as described above. I accept full responsibility for these risks. **[Skip Section B, and proceed to Section C for signatures.]**

Initial: _____ **Option 2:** By signing below, I hereby decline and DO NOT CONSENT TO RECEIVE ANY BLOOD OR BLOOD PRODUCTS, **EXCEPT** I DO CONSENT TO RECEIVE PRODUCTS THAT I HAVE CHECKED IN **SECTION B** (BELOW) IF MY PHYSICIAN BELIEVES THEY ARE RIGHT FOR MY ILLNESS. By limiting my consent to getting only those products I have checked in Section B, I realize the risks to me could include added medical problems, complications of current medical problems, major injury, or death, as described above. I also realize there are no other natural products and no artificial products that can perform all the functions of blood. I realize there are risks linked to getting those blood products to which I have consented in Section B. These risks include but are not limited to: severe risks (viruses including hepatitis virus, HIV, and bacteria causing sepsis; lung damage; blood clots; death), and less severe but still major risks (fever; allergic reactions including wheezing, facial swelling, rash, itching; nausea/vomiting; shortness of breath; too much iron; headache; back and chest pain; changes to blood pressure). I accept full responsibility for these risks. **[Proceed to Section B to select the products you consent to receive, then proceed to Section C to sign.]**

SECTION B: BLOOD AND BLOOD PRODUCTS. Check all products you CONSENT to receive:

Blood Products:

❑ RBC/Packed Red Blood Cells ❑ Cryoprecipitate ❑ Platelets
❑ Fresh Frozen Plasma ❑ Granulocytes / White Blood Cells ❑ Intraoperative Blood Salvage (cell saver-a continuous circuit)
❑ Other_____

SECTION C: SIGNATURES. By signing below, I hereby REFUSE blood products as delineated in my selections above in Section A and Section B (if B applies). I have read this form or it has been read to me. I accept its terms and I have been given the chance to ask questions, which have been answered. I realize that if I am an adult signing on behalf of a minor patient, Emory Healthcare may be legally compelled to provide blood or blood products to the minor patient. If I am signing on behalf of an adult patient who does not have decision making capacity, I realize that I must make decisions that the patient would want.

_____	_____	_____	_____
Signature of Patient	**Date**	**Signature and Printed Name of Witness**	**Date**

(Make Every Reasonable Effort to have a Witness observe the discussion of refusal of blood transfusions, or limited blood product transfusions, and then to sign this form)

_____	_____	_____
Signature and Printed Name of Next of Kin, or other Authorized Person	**Date**	**Relationship of Next of Kin, or other Authorized Person to Patient**

If patient lacks decision making capacity, the Next of Kin or other Authorized Person may sign on patient's behalf. Even if the patient does have capacity and signs this form, make every reasonable effort to have next of Kin or other Authorized Person also sign this form acknowledging that he/she understand the patient's wishes.

Physician statement: I have discussed the content of this form, including the likely risks, complications, and likely results with the patient and/or patient's Authorized Representative. If the patient is or could be pregnant, I have discussed likely risk to the fetus. I realize that I am responsible for requesting an Ethics Consult if this form is signed by a pregnant patient if the refusal could jeopardize the life or health of the fetus, or if the patient is a minor or an adult who lacks decision making capacity and the refusal of blood products could jeopardize the patient's life or health.

_____	_____	_____
Signature of Physician	**Printed Name of Physician**	**Date**

REFUSE TRANSFUSION