



## Authorization for Transfusion Blood/Blood Products

Patient's Name: \_\_\_\_\_

I hereby authorize Dr. \_\_\_\_\_ or his/her designee and such other physicians or allied health professionals as are needed to assist him/her to perform **blood/blood products transfusion(s)**. I understand in general what a blood/blood product transfusion is and the procedures that will be used. I understand that my physician or designee will decide the amount and type of blood product needed based on my particular needs to stabilize my condition or save my life.

I have had explained to me in connection with the potential benefits transfusion of blood/blood product the nature and purpose of the proposed transfusion and the reasonably foreseeable risks and alternative to the transfusion of blood and blood products. I also understand the consequences of not receiving transfusion and have decided that the benefit to me exceeds the risk.

I am aware that, in addition to the reasonable foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. Specifically, in obtaining my informed consent to the transfusion of blood/blood products, I have been informed of the following reasonable foreseeable risks. There is a small risk of potentially serious infectious disease transmission despite careful donor selection and testing of blood products prior to use. The risk of transmission of HIV (the virus which causes AIDS) and of Hepatitis C is approximately 1 in 1,900,000. The risk of Hepatitis B is estimated to be about 1 in 100,000. Due to our geographic location, there is also an unknown risk of a tick borne illness called Babesia. There are other infectious diseases, both known and unknown, which are potentially transmittable.

Blood transfusion reactions which may include:

- Itching
- Nausea or vomiting
- Severe Allergic reaction
- Abnormal Blood clotting
- Shortness of breath (*which may be attributed to Transfusion associated with Acute Lung Injury*)
- Shaking and/or chills
- Unexplained Pain
- Low or High blood pressure
- Rash
- Fever
- Destruction of Red Blood cells

If one of the more severe reactions occurs, they may result in possible organ and/or tissue damage or even death.

\_\_\_\_\_ Patient Initials



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This consent will be valid for the duration of my inpatient stay, or for 6 months of outpatient visits and this consent may be revocable by me at any time, except to the extent it has been relied upon.

\_\_\_\_\_  
(MD., DO, APRN, PA)

Signed: \_\_\_\_\_  
(Patient or legally authorized representative)

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter responsible for explaining procedures and special treatment:

\_\_\_\_\_ (Interpreter)

or, telephone consent obtained by: \_\_\_\_\_

Witness (if telephone consent): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**PATIENT UNABLE TO SIGN [ ] BECAUSE:**

\_\_\_\_\_

\_\_\_\_\_ M.D., PA, APRN Date: \_\_\_\_\_ Time: \_\_\_\_\_

\_\_\_\_\_ Witness Date: \_\_\_\_\_ Time: \_\_\_\_\_