

# TRANSFUSION OF BLOOD AND BLOOD PRODUCTS CONSENT



I, \_\_\_\_\_ understand that in my hospital treatment I may need a transfusion of blood or blood products which may include:

- Blood Products (packed red blood cells, plasma, Convalescent Plasma, platelets, or cryoprecipitate)
- Blood Product Derivative (RHIG, Factor VIII, Winrho)
- Other Blood Product Derivative, \_\_\_\_\_ (as explained by my physician/provider)

I have been told and I understand about the risks and benefits, possible alternatives, and complications associated with transfusion. These risks and complications include a reaction to the blood and the transmission of infectious diseases including viral hepatitis and AIDS. I agree to accept blood and/or blood products if my physician/provider determines it is necessary. No express or implied warranty as to the blood products and their transfusion is made by the hospital, my physician(s)/provider(s), or the Blood Bank.

SIGN: _____	DATE: _____	TIME: _____
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(In case of a minor or of a patient unable to sign, signature of legal representative is necessary.)

WITNESSES:

SIGN: _____	DATE: _____	TIME: _____
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SIGN: _____	DATE: _____	TIME: _____
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## AFFIRMATION OF INFORMED CONSENT BY ORDERING PHYSICIAN/PROVIDER

I have informed the above named patient or the person authorized to extend consent on the patient's behalf, of the medical condition requiring transfusion. I have explained, consistent with accepted medical judgement, the reasonable (1) possible alternatives, (2) risks and benefits, and (3) complications.

Physician/Provider::

SIGN: _____	DATE: _____	TIME: _____
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I request that no blood or blood derivatives be administered to \_\_\_\_\_ during this hospitalization. I release the hospital, its personnel and the attending physician/provider from any responsibility whatever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood and its derivatives and I fully understand the possible consequences of such refusal on my part.

SIGN: _____	DATE: _____	TIME: _____
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WITNESSES:

SIGN: _____	DATE: _____	TIME: _____
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SIGN: _____	DATE: _____	TIME: _____
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**Southern Ohio  
Medical Center**

*Very good things are happening here*

N0039  
Revised T Shope 09/21  
trans\_blood

Sex: \_\_\_\_\_ FC: \_\_\_\_\_  
DOB: \_\_\_\_\_

03/23/22