SUN COUNTRY HEALTH REGION
&
AFFILIATES

Consent for Administration of Blood / Blood Products

Client Name: ______________________________
Address: ______________________________
DOB: _____/_____/________ HSN# : ______________
mm dd yyyy

I, ____ consent, or give consent for
(undersigned)

____ to receive the following blood products.
(patient's name or self)

a) __________ red blood cells b) ____________ platelets c) ____________other

Patient's statement of consent: I have been advised of the risks associated with the administration of these blood products and have been advised of any alternatives that may be available for my (or the patient's) condition. I acknowledge that any products obtained from human sources may contain unknown agents that may transmit disease. I consent to the use of blood products as deemed necessary during the course of my treatment.

Physician's Statement: I have explained the risks of transfusion to this patient, guardian or legal representative and have presented any alternatives that could be reasonably employed instead of blood transfusion. In my opinion the person signing the consent understood the content of this consent.

Date: ____________________________

____
(Signature of Physician)

____
(Signature of patient, guardian or legal representative*)

____
(Printed name of Physician)

____
(Relationship to Patient)

* Legal representative as defined in the SCHR Policy

Consent not obtained (please specify reason(s)):

____

____

____

____

____
Date

____
Signature of Physician

NUR-GenAcute030/I9-Dec-2008

SUN COUNTRY HEALTH REGION
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Refusal to give Consent for Administration of Blood / Blood Products

Client Name: ________________________
Address: ________________________
DOB: _____/_____/________ HSN# : ____________
mm dd yyyy

I, ______________________________ refuse to give consent for
(undersigned)

______________________________ the transfusion of blood or blood products.
(patient's name or self)

Patient's statement of refusal: I acknowledge that I have been informed of the risk involved and hereby release the attending physicians and the Sun Country Health Region from all responsibility for any ill effects which may result from such action.

Physician's Statement: I have explained the risks of refusing blood or blood products to this patient, guardian or legal representative. In my opinion the person signing the refusal understood the content of this refusal.

Date: ______________________

____
(Signature of Physician)

____
(Signature of patient, guardian or legal representative*)

____
(Printed name of Physician)

____
(Relationship to Patient)

* Legal representative as defined in the SCHR