

**TRANSFUSION SERVICE  
CONSENT AND AUTHORIZATION FOR  
BLOOD PRODUCT AND BLOOD DERIVATIVE ADMINISTRATION**

*Sinai Hospital encourages and supports your participation in decisions concerning your health care. Your physician will provide you with the necessary information and advice to help you reach an informed decision. You have the right to accept or refuse treatment recommended by your physician.*

1. I am being asked to give my consent for the transfusion of blood and blood products/derivatives in the event that a transfusion is considered necessary by my physician, Dr \_\_\_\_\_ or any assistants. I have been informed about transfusion options, alternatives, risks and benefits. Additionally, options and alternatives such as \_\_\_\_\_ have been discussed.
2. I understand that blood products and blood derivatives are not always successful in producing a desired result. Despite extensive testing of donor blood and blood products/blood derivatives, they may carry some life-threatening risks such as, but not limited to, hepatitis viruses, viruses that cause AIDS and other infectious diseases as listed below. Extensive testing of donor blood is performed at the donor center/manufacturer to avoid complications.
3. Relatively few blood products transmit a viral disease. In addition to infection, other types of serious reactions to transfusions may include allergic or immune reactions, impaired organ function and other minor side effects. I understand that donation and receipt of my own blood is not risk free. Infection and other serious side effects can occur.
4. I understand that no guarantee or warranty applies to the blood and/or blood products/derivatives that may be supplied to me.

The following are approximate frequencies of diseases transmitted by blood after screening:

Cause	Some Possible Disease Produced	Frequency per Donors
HIV - 1/2	AIDS	1 : 2,000,000
HTLV - 1 AND HTLV - 2	Paralysis/Leukemia	1 : 3,000,000
HCV	Hepatitis/Cirrhosis	1 : 1,900,000
HBV	Hepatitis/Cirrhosis	1 : 269,000
Immunity	Various life threatening reactions	1 : 1,000,000
West Nile Virus	Meningitis, Encephalitis	1 : 4,000 (Aug/Sept)
CJD		Unknown
CMV		1 : 40 (unfiltered sero-positive donor, susceptible patient)

**I understand the potential risks, benefits, and alternatives available to me. My questions have been answered and I accept this treatment.**

SIGNATURE OF PATIENT		NAME / SIGNATURE OF PERSON AUTHORIZED TO CONSENT FOR PATIENT	
DATE	TIME	(Check One) <input type="checkbox"/> Surrogate <input type="checkbox"/> Health Care Agent <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Telephone Consent	
SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN WHO EXPLAINED PROCEDURE TO PATIENT	
WITNESS NAME (please print)		PHYSICIAN NAME (please print)	PAS #

**INFORMED REFUSAL OF RECOMMENDED ADMINISTRATION OF BLOOD/BLOOD PRODUCTS**

I certify by my signature below that I am a competent adult over the age of 18, and that I refuse any transfusion of blood or blood product derivatives during this hospitalization. I hereby release the hospital, it's personnel, attending physicians, surgeon, assistant, and the anesthesiologist from any responsibility whatever for unfavorable reactions or any unoward results due to my refusal to permit the use of blood or derivatives, and fully understand the possible consequence of such refusal on my part.

My physician, Dr. \_\_\_\_\_, has discussed the risks, benefits, and alternatives of this treatment with me. I understand that by refusing this treatment, I am at risk and I accept those risks.

I refuse this procedure \_\_\_\_\_ (Signature of Patient / Surrogate)