New Hanover Regional Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#: _____ CSN#: _____

CONSENT/REFUSAL FOR TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

What are the potential benefits of receiving a blood product transfusion?

- Transfusions assist with treating blood loss, improve clotting, and/or increase blood volume.
- May include the use of red blood cells, platelets, plasma, and/or cryoprecipitate.
- May temporarily improve anemia-related symptoms by increasing the amount of oxygen-carrying red blood cells.
- May prevent serious illness and/or death.

What are some of the potential risks of receiving a blood product transfusion?

- Allergic reaction
- Transfusion-Associated Circulatory Overload
- Transfusion-Related Acute Lung Injury
- Transfer of viruses (HIV, Hepatitis, etc.)
- Septic-transfusion reaction
- Hemolytic or febrile non-hemolytic reaction
- In rare occurrences, kidney failure and/or death

Consent for Blood Product Transfusion

I consent to the transfusion of any blood or blood products deemed necessary for my medical care throughout the duration of my hospital stay. I acknowledge that my physician has explained the risks, benefits, and alternatives of transfusion. I have been given the opportunity to ask questions and understand that there is no guarantee that the transfusion will benefit me.

Signature of Patient/Patient Representative: _____

Printed Name: _____

Relationship to Patient: _____ **Date and Time:** _____

Refusal of Consent for Blood Product Transfusion

I refuse to consent in receiving any type of blood or blood products. I have been given the opportunity to ask questions. I understand the consequences of not receiving blood therapy as they have been explained to me, and release the hospital of any liability regarding any unfavorable result.

Signature of Patient/Patient Representative: _____

Printed Name: _____

Relationship to Patient: _____ **Date and Time:** _____

Limited Consent/Alternatives Only

I consent to the following treatments, procedures, and/or plasma fractions. Check the box that best applies to your decision.

☐ **I will accept blood fractions, such as albumin, erythropoietin, clotting factors, immunoglobulins, etc.**
☐ **I will accept procedures that return my own blood to me, such as cell salvage, dialysis, etc.**

Comments (please list any treatments, procedures, or plasma fractions that you refuse): _____

_____

Signature of Patient/Patient Representative: _____

Printed Name: _____

Relationship to Patient: _____ **Date and Time:** _____

If patient is unable sign, state the reason: _____

I have personally explained the above information to the patient or person authorized to consent for patient.

Physician Signature: _____ **Date and Time:** _____

I do certify that the above name patient (or representative) signed this document in my presence.

Witness Signature: _____ **Date and Time:** _____

Witness Signature: _____ **Date and Time:** _____

***A second witness is required for telephone consents, or when the patient is unable to make this decision, and there is not a representative for the patient available to sign or speak for the patient.**

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD

New Hanover Regional Medical Center

NHRMC BLOODLESS PROGRAM ENROLLMENT

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

DOB: _____ MRN#: _____

HAR#: _____ CSN#: _____

Please read all of the details carefully prior to completion of this form.

By signing this form, you are declaring your REFUSAL of major blood product components, such as red blood cells, platelets, plasma, and cryoprecipitate, as well as your enrollment into the NHRMC Bloodless Program.

A Durable Power of Attorney (DPA) or advance directive must be completed and a copy must be provided so that it is placed in your medical record in order to enroll in the program. Enrollment in the program does not take the place of having a DPA, and in an emergent situation where a DPA or advance directive is unavailable you are unconscious and do not have a representative present, a blood transfusion may be given in order to preserve your life.

If changes need to be made to this form in the future, you are required to re-enroll in the program. Please allow the time for these changes to be completed by re-enrolling prior to your hospitalization/surgery date. Your DPA or advance directive should reflect any changes made. You have the right to change the contents of this form at any time, as well as opt out of the program. If you opt out of the program, a consent form to receive transfusions will be provided to you at your next admission.

If you choose to accept a directed donation or pre-donate your own blood (autologous donation) prior to a procedure, or accept one of the major components of blood products, you will not qualify to enroll in this program.

I have spoken with my physician and understand the risks and benefits and consequences involved with refusing a transfusion, as well as refusal of any other alternative treatments (if indicated) even if it is believed to possibly save my life.

Signature of Patient/Patient Representative: _____

Relationship: _____

Witness Signature: _____ **Date and Time:**_____

Witness Signature: _____ **Date and Time:**_____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD