BRONSON

Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Administration of Blood/Blood Products

I agree to blood product transfusions the doctor decides are necessary or recommended.

The blood products may include:

- Packed red blood cells
- Fresh frozen plasma
- Cryoprecipitate
- Platelets
- Whole blood

The doctor has told me that I may need a transfusion to:

- Replace red blood cells to correct anemia
- Improve oxygen transport in the blood
- Help stop bleeding

I know that medicine is not an exact science. No one has made promises about my treatment or care. I can choose not to have a transfusion.

I understand that transfusion may be necessary to preserve my life. The transfusion may be necessary to prevent serious organ damage, when other treatments have failed.

The blood products I will receive have been tested by all FDA approved tests for infectious agents. I know that there are risks to having a blood transfusion. The most common risks include:

- Fever
- Rash
- Itching hives

Rare reactions are:

- Hemolysis, the abnormal breakdown of red blood cells.
- Lung injury causing shortness of breath.

I have been told of other treatment options.

I have been given the chance to ask questions. I understand the answers I have been given.

If the patient is unable to sign or is a minor, complete the following:

Patient is a minor _____ years of age or is unable to sign because:

_____

_____

_____

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Closest relative (relationship) _____ ☐ Guardian/POA Healthcare

Witness Signature: _____ Date: _____ Time: _____

Interpreter's Statement: I have interpreted the text on this consent to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____