Affix Patient Label

Patient Name: Date of Birth:

Informed Consent: Blood Conservation

☐ **Category One:** I DO Not want any transfusion of:

- ☐ Whole blood
- ☐ Red Blood cells
- ☐ White Blood Cells
- ☐ Platelets
- ☐ Plasma (includes FFP) to be used in my medical treatment

Even if my doctor tells me the products will:

- Keep me alive
- Avoid permanent damage to tissue, organs, or body functions

☐ **Category Two:** I want to reduce my exposure to blood transfusion. I want my doctor to use methods to keep and make the most of my own blood supply if needed. I understand this may reduce the need for blood therapy. I understand I may need blood therapy at some future time in my medical care.

No matter which category you choose, check the following choices regarding blood fractions, procedures, and treatments.

☐ **I accept minor blood fractions:**

- ☐ Albumin/Plasmanate®
- ☐ Erythropoietin
- ☐ Floseal®
- ☐ Tisseel®
- ☐ Immunoglobulin
- ☐ Cryoprecipitate
- ☐ Clotting factors (fibrinogen, Factor VII, VIII, IX, and XII)
- ☐ Other ______________________________

☐ **I refuse all minor blood fractions.**

I accept the following procedure or treatment:

- ☐ I am willing to receive bone, tissue, and muscle transplant.
- ☐ Dialysis
- ☐ Blood salvage during or after surgery
- ☐ Heart lung machine autologous blood
- ☐ Acute normovolemic hemodilution
- ☐ Other: ______________________________

☐ **I refuse all procedures or treatments.**

The risks and benefits of blood transfusion and refusal of blood have been explained to me. 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: __________