



Affix Patient Label	
Patient Name: _____	Date of Birth: _____

Informed Consent: Blood Conservation

Category One: I DO Not want any transfusion of:

- | | |
|--|--|
| <input type="checkbox"/> Whole blood
<input type="checkbox"/> Red Blood cells
<input type="checkbox"/> White Blood Cells | <input type="checkbox"/> Platelets
<input type="checkbox"/> 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, o 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:

- | | |
|---|--|
| <input type="checkbox"/> Albumin/Plasmanate®
<input type="checkbox"/> Erythropoietin
<input type="checkbox"/> Floseal®
<input type="checkbox"/> Tisseel® | <input type="checkbox"/> Immunoglobulin
<input type="checkbox"/> Cryoprecipitate
<input type="checkbox"/> Clotting factors (fibrinogen, Factor VII, VIII, IX, and XII)
<input type="checkbox"/> 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

Witness Signature: _____ Date: _____ Time: _____

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

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