HGH
COMPASSION INNOVATION EXCELLENCE

Consent for Blood Components And/or Blood Products

I have been informed by my physician or authorized practitioner, that in the course of my medical/surgical treatment, I may need a transfusion of blood components and/or blood products.

The Physician/Health Practitioner:

- Has explained the reason for and a description of the blood component or the blood product that I need;
- Has explained the risks and benefits, including life-threatening risks; and
- Alternatives, if appropriate to clinical circumstances, including benefits and risks.

- Has informed me about other possible or available options to blood transfusion including the risks and benefits;
- Has informed me about the possible consequences if I refuse the blood components and/or blood products; and
- Has answered my questions about the treatment.

I have read (or the document has been read to me) and understand all the above. I consent to the transfusion of blood components and/or blood products if it becomes necessary during the course of treatment.

Patient or Substitute Decision Maker (SDM)	Signature	Date (yyyy/mm/dd)
I refuse to receive blood and/or blood products		
Patient or Substitute Decision Maker (SDM)	Signature	Date (yyyy/mm/dd)

TO BE COMPLETED BY PHYSICIAN /HEALTH PRACTITIONER

(please note that as per HGH Consent to Treatment Policy section 3.6.4, «treatement may be delayed in the absence of Health Practioner's signature.»

I confirm that I have explained the nature of the blood transfusion, expected benefits, material risks, material side effects, special and unusual risks, alternative courses of action and the likely consequences of not receiving the blood transfusion. I have responded to all requests for additional information regarding the above.

Duration of consent for blood transfusion (please check one).

☐ Valid for current admission. ☐ Valid as part of an ongoing treatment plan up to 12 months.

Health Practitioner / Physician (Name)	Signature	Date (yyyy/mm/dd)

Nom de l'interprète (s'il y a lieu)	Interpreter Signature	Date (yyyy/mm/dd)
TELEPHONE CONSENT Name of Substitute Decision Maker (SDM)	Signature (staff confirming telephone consent)	Date (yyyy/mm/dd)

ALTERNATIVE OPTIONS CHECKLIST
For patients who wish to refuse Blood transfusion for personal or religious reasons

The intent of this form is to guide the discussion between a physician and patient about the patient's selected options for blood transfusion and alternatives. This form is used in association with obtaining consent for refusal of blood and blood components. The patient or substitute decision maker should check and initial intent for each item below:

	Accept	**Refuse**
Blood components		
Red Blood Cells	☐ _____	☐ _____
Plasma	☐ _____	☐ _____
Platelets	☐ _____	☐ _____
Cryoprecipitate	☐ _____	☐ _____
Blood Products		
Albumin	☐ _____	☐ _____
Plasma-derived clotting factors	☐ _____	☐ _____
Immune globulins	☐ _____	☐ _____
Fibrin sealants	☐ _____	☐ _____
Drugs		
Erythropoetin (some formulations may contain albumin)	☐ _____	☐ _____
Recombinant clotting factors	☐ _____	☐ _____
Procedures		
Acute normovolemic hemodilution **(n/a at HGH)**	☐ _____	☐ _____
Intraoperative or postoperative cell salvage **(n/a at HGH)**	☐ _____	☐ _____
Controlled hypotension (**n/a at HGH)**	☐ _____	☐ _____

My signature below indicates that I request only the alternatives to blood transfusion which I have designated above. I acknowledge that all my questions have been answered to my satisfaction.

Patient's printed name	Signature	Date (yyyy/mm/dd)
Substitute Decision Maker's (SDM) printed name	Signature	Date (yyyy/mm/dd)

STATEMENT OF PHYSICIAN/HEALTH PRACTITIONER

I confirm that I have explained the nature of the product/treatments and for those applicable to the patient, the expected benefits, material risks, and material side effects. I have answered all questions asked by the patient or the patient's substitute decision maker.

Health Practitioner / Physician	Signature	Date (yyyy/mm/dd)