



Consent or Refusal for Transfusion of Blood Components and/or Products

A copy of this form MUST be on the patients's chart

The physician or health care practitioner has fully explained to me:

- What is a blood transfusion
- The reason for the blood transfusion
- How the blood transfusion will benefit me
- What are the possible risks and side effects of a blood transfusion
- What may happen if I do not have a transfusion
- What other choices of treatment I have and their risks and side effects

I have had the opportunity to ask questions, which were answered to my satisfaction. Yes No Initials

TO BE COMPLETED BY PATIENT OR SUBSTITUTE DECISION MAKER

I was given a copy of "Blood Transfusion – Information for Patient's Booklet"

I **AGREE** to receive blood and / or products

I **AGREE** to receive **ONLY** those blood components/products/procedures selected on the "OPTIONS FOR PATIENTS OBJECTING TO BLOOD TRANSFUSIONS" form (see back for consent)

Signature of Patient (or Substitute Decision Maker)

Date (dd/mm/yyyy)

Print Name of Patient (or Substitute Decision Maker)

I **REFUSE** to receive **any** blood component and / or products.

Signature of Patient (or Substitute Decision Maker)

Date (dd/mm/yyyy)

Print Name of Patient (or Substitute Decision Maker)

TO BE COMPLETED BY PHYSICIAN / HEALTH CARE PRACTITIONER

I confirm that I have explained the nature of the treatments(s), expected benefits, material risks, alternative course of action as well as the likely consequences of not having the treatment to the above patient / substitute decision maker and answered all questions.

Signature of Physician / Health Care Practitioner

Date (dd/mm/yyyy)

Printed Name of Physician / Health Care Practitioner

Transfusion Consent Type:

- Specific procedure or event (valid for specific procedure or event or duration of admission)
- Ongoing transfusion therapy – is part of the disease treatment plan (valid for duration of disease treatment)

Emergency Transfusion, no consent:

I certify that, due to the urgent need for transfusion, I am unable to obtain informed consent prior to therapy and that I have no advance directive indicating that transfusion in reasonable circumstances is rejected.

As mandated in the HEALTH CARE CONSENT ACT, Section 25.5, the Physician/Health Care Practitioner must promptly note on the patient's health record the opinions that are held by the practitioner on which he or she relied.

Signature of Physician/Health Care Practitioner

Print Name of Physician/Health Care Practitioner

Date (dd/mm/yyyy)

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Options for Patients Objecting to Blood Transfusions

	Patient should check ✓ and initial each item	
	Accept	Refuse
Blood Components		
Red blood cells.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Plasma (Frozen plasma).....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Platelets.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Cryoprecipitate.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
White Blood Cells.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Blood Components		
Albumin.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Plasma-Derived Clotting Factors (Fibrinogen, PCC, FEIBA).....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Plasma-Derived Proteins (C1 esterase inhibitor).....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Immune Globulins (IVIG, Rhlg, Hepatitis B Ig, CMV Ig, etc).....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Recombinant Blood Proteins		
Recombinant Clotting Factors (FVIII, FIX, FXIII, rFVIIa).....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Alternatives to Transfusion		
Erythropoiesis Stimulating Agents (do <i>NOT</i> contain albumin)		
● darbepoetin alfa.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
● epoetin alfa.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Topical fibrin or thrombin Brand: _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Hemodialysis.....	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Specify other treatment: _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
Signature of Patient (or Substitute Decision Maker)		Date (dd/mm/yyyy)
Print Name of Patient (or Substitute Decision Maker)		Relationship to Patient
<u>STATEMENT OF PHYSICIAN / HEALTH CARE PRACTITIONER</u>		
I confirm that I have explained the nature of the treatments(s), expected benefits, material risks, alternative courses of action as well as the likely consequences of not having the treatment to the above patient / substitute decision maker and answered all questions.		
Signature of Physician / Health Care Practitioner		Date (dd/mm/yyyy)
Print Name of Physician / Health Care Practitioner		

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Adapted from St. Michael's Hospital, Toronto; November 2015



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