GOOD SHEPHERD MEDICAL CENTER

CONSENT FOR TRANSFUSION OF BLOOD
OR BLOOD PRODUCTS

My physician has informed me that I need, or may need during treatment, a transfusion of blood and/or one of its components in the interest of my health and proper medical care.

My physician has described to me the risks and benefits of receiving transfusion(s). These risks exist despite the fact that the blood has been carefully tested. The risks that are associated with the transfusion of blood or blood products may include but are not limited to:

1. Fever
2. Allergic reactions such as hives
3. Transfusion reaction which may include kidney failure or anemia
4. Heart failure
5. Hepatitis
6. AIDS (Acquired Immune Deficiency Syndrome)
7. Other infections
8. Death
9. Transfusion Related Acute Lung Injury - "TRALI"
10. Volume Overload

SAFETY QUESTIONS
ANSWER THE QUESTIONS BELOW BEFORE PROCEEDING WITH CONSENT

1. Do you have any antibodies to red blood cells or is it difficult to find compatible blood? Yes No Unknown
2. Have you ever received irradiated blood? Yes No Unknown
3. Have you ever had a reaction to a blood transfusion? Yes No Unknown

****If the patient answers yes to any of the above questions notify Blood Bank , document below who you notified in the Blood Bank, and fax a copy of the completed blood consent to the Blood Bank ****

Name of Person contacted in the Blood Bank:______________________ Date/time______________________

To enhance the safety of the nation's blood supply, the FDA requires blood centers to perform a more sensitive test to detect infectious diseases
using a method called nucleic acid testing (NAT). The NAT test is performed in conjunction with the current mandated FDA tests

The alternatives to transfusion, including the risks and consequences of not receiving this therapy, have been explained to me. I have had the opportunity to ask questions, and consent to the transfusion(s).

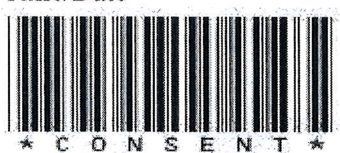
✓ ______________________ __________ ✓✓ ______________________ __________
Patient/other legally responsible person Date/Time Witness Date/Time

I have had the opportunity to ask questions, and refuse the transfusion(s).

______________________ __________ ______________________ __________
Patient/other legally responsible person Date/Time Witness Date/Time

I have discussed with this patient the need of, risk of, and alternatives to blood transfusion.

✓✓✓
____
Time/Date Physician signature
DOUGLAS A. WALDMAN, MD



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