

CONSENT FOR TRANSFUSION OF BLOOD AND/OR BLOOD PRODUCTS

Re: _____
(Print Name of Patient)

1. My health care provider, (printed name) _____ has told me that during my treatment it may be necessary to receive a transfusion of blood and/or blood products such as red blood cells, plasma, cryoprecipitate, or platelets.
2. My health care provider has also told me about the risks of receiving a transfusion from volunteer donors. I understand that risks exist even though the blood and/or blood products have been tested. I understand that in most cases the risks are small, however in some cases serious injury and/or death may result.
3. My health care provider has discussed with me autologous blood donation and other suitable treatments. I have been told that even if my own blood is used, it may still be necessary to give me other blood and/or blood products.
4. I have been given information on blood and/or blood products for transfusion and the chance to ask questions about the benefits and risks of blood and/or blood products for transfusion. My health care provider has answered my questions to my satisfaction.

I consent to the transfusion of blood and/or blood products if it becomes necessary during the course of my treatment.

EXCEPTIONS TO CONSENT: This patient has indicated special instructions for the transfusion of blood products:

(Patient's Initials)

Signature (Patient or Substitute Decision Maker*):

Printed name (If Substitute Decision Maker)

Date

Signature of Prescriber

Printed name

*** Possible Substitute Decision Makers include:**

- A Committee of the Person, as appointed by a Court Order
- A Representative as appointed by a "Standard" Representation Agreement (restrictions apply) & defined by the "Representation Agreement Act".
- A Representative as appointed by an "Enhanced" Representation Agreement & defined by the "Representation Agreement Act".
- A "Temporary Substitute Decision Maker" [*Appointment of a Temporary Substitute Decision Maker* form (PHC-MR081-page 1) must be completed OR a TSDM referral made to the office of the Public Guardian & Trustee (PHC-MR081-page 2)]

This form will remain valid only for the duration of hospital stay or treatment course (renew yearly). **Please verify date of signature.**

For additional information on Informed Consent for Blood/Blood Products visit the Providence intranet website:

<http://intranet.phc.ca >Policies and Manuals > Transfusion Medicine>

Laboratory: Tel: 604-806-8003 Fax: 604-806-8627

