| Name _____<br>MRN _____<br>DOB _____<br>(Patient identification or label) | VCU Health<br>VCU Medical Center<br>Richmond, Virginia<br>**Patient Acknowledgement of Informed Consent/ Refusal for**<br>**Transfusion of Blood and Blood Products** |
|---|---|

I understand that the VCU Health System/MCV Hospitals and Physicians, through its providers and employees, may need to administer blood and/or blood products to the above named patient in the interest of proper medical care.

I have been informed that there are different sources of blood, including self-donated blood (autologous), banked blood (allogenic), and directed donor blood from family members and friends, and that their use is dependent upon the clinical situation. I understand that if an emergency occurs, banked blood (allogenic) will most likely be used.

I have been informed that despite careful screening in accordance with national and regional regulations, there are rare instances of life-threatening infection resulting from transfusions, such as viral hepatitis, HIV/AIDS, bacterial infections and other infectious agents as yet known and unknown for which definitive screening tests do not exist.

I also understand there is no practical way to eliminate all of these risks. In addition, I understand that unpredictable reaction to transfusions may occur which include fever, shortness of breath, shock and even death.

I have been informed that the expected benefits of the transfusion may include minimizing shock, brain or other organ damage, and limiting blood loss. I understand there are no guarantees offered as to the expected benefits of the transfusion.

I have had the opportunity to ask questions about transfusions, alternative treatments, their risks, and risk of no treatment.

I understand that transfusions will be given only when medically indicated. Consent is valid for the duration of this admission. In the outpatient setting, this consent is valid for 12 months from signature date.

I acknowledge that the material on this form has been fully explained by the provider below and that I have read it or have had it read to me, and that I understand its content.

## I <u>CONSENT</u> to the Transfusion of Blood And Blood Products

I understand that I can withdraw my consent at any time.

**SIGNED:** _____ _____ _____ _____
**Patient** or Person Authorized to Sign for Patient | Relationship to Patient | Date | Time

**Provider:** _____ _____ _____ _____
**Provider Signature** | **Provider Printed Name**/ Number | Date | Time
Individual Obtaining Informed Consent (two individuals for telephone consent)

**Interpreter** or Witness: _____ _____ _____
(if needed) Signature/Printed name/Interpreter number | Date | Time

## Informed <u>REFUSAL</u> (ONLY)

**I have reviewed the above information and <u>REFUSE</u> transfusion of blood and blood products.**

**I <u>do accept</u> receiving derivatives of blood products** to include: _____

I understand that I can change this decision by providing written consent to blood transfusions at any time.

**SIGNED:** _____ _____ _____ _____
**Patient** or Person Authorized to Sign for Patient | Relationship to Patient | Date | Time

**Provider:** _____ _____ _____ _____
**Provider Signature** | **Provider Printed Name**/ Number | Date | Time
Individual Obtaining Informed Consent (two individuals for telephone consent)

**Interpreter** or Witness: _____ _____ _____
(if needed) Signature/Printed name/Interpreter number | Date | Time

*DT-CONSENT-T*