Eaton Rapids Medical Center

CONSENT TO, OR REFUSAL OF, BLOOD/BLOOD PRODUCT TRANSFUSION(S)

I hereby consent to the administration of blood/blood product transfusion(s) that are needed in my care. I have read or had it explained to me the need for _____ the risks of the transfusions, the benefits to be expected, the alternatives to the use of blood/blood product, and the information concerning blood/blood product testing as noted below. I know the likely result if blood/blood product is not given. I have been given the opportunity to ask questions and any questions I have asked have been answered or explained in a satisfactory manner. I understand the information explained to me and consent to the necessary blood/blood product transfusion(s).

The most common concern of transfusion is an occurrence of transfusion reaction. These reactions tend to occur because of the body's reaction to foreign proteins. Commonly, this reaction shows itself as fever, chills, and general body ache. Rarely, a transfusion reaction can lead to kidney damage. While the transfusion is being given to you, you are carefully monitored for evidence of transfusion reaction, and should symptoms appear, the transfusion is immediately stopped and tests are performed to check for reaction.

A second concern of transfusion is the possible transmission of hepatitis. The incidence of hepatitis from transfusion in this area is low. One reason for the low incidence is that blood products used in this area are obtained from voluntary blood donation through the Red Cross. People who donate under these circumstances tend not to be drug users or alcoholics, who sometimes sell their blood to non-Red Cross blood banks. All blood units and components are tested for viral hepatitis, but there are certain viruses which are presently not detectable by available lab tests.

A third concern in transfusion is the transmission of viruses, such as Human Immunodeficiency Virus (HIV). All blood is carefully tested for the presence of HIV, and in this area, the incidence of either of this virus is very low. No unit of blood, which is found to be positive on the HIV screening test have been transfused, and most of the positive units, when re-tested by more specific tests, have, in fact, were negative units. Again, this use of voluntary donations of blood to the Red Cross means that known high-risk donors such as homosexuals and drug users are rejected. Thus, the incidence of contaminated blood is very low in this area.

There are other complications of blood product transfusion, including but not limited to death, but those mentioned above are the most common.

Your doctor is aware that these risks of blood product transfusion exist. He/she has determined that the risks associated with receiving a blood product transfusion are less than the risks of not receiving a transfusion.

Blood Transfusion and/or Blood Component Administration Information Sheet **given to patient:** ☐ Yes ☐ No

I agree to receive blood product(s)

☐ I have read or have been read the above information and understand the explanation of the risks of transfusion, and agree that despite the risks of transfusion, I will undergo transfusion during this visit/admission to the Hospital.

I refuse blood product(s)

☐ I hereby release the hospital, its personnel and the physicians from any responsibility whatever from unfavorable reactions or any problematic results due to my refusal to permit the use of blood or its derivatives, and I understand the possible consequences of such refusal on my part.

Eaton Rapids Medical Center

CONSENT TO, OR REFUSAL OF, BLOOD/BLOOD PRODUCT TRANSFUSION(S)

BY SIGNING THIS FORM, I CERTIFY:

- That I have read or had this form read and/or this form explained to me.
- That I fully understand its contents.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That information was provided through direct conversation with my physician and/or other health care providers in terms; language that I understand.

Date	Time	*Signature of patient
Date	Time	Signature of legal representative
Date	Time	Relationship to patient
Date	Time	Witness
Date	Time	*Witness

*If the client signs with an "X" two witnesses are required.

PROVIDER ACKNOWLEDGEMENT

By signing this form, I certify that I or my physician associate has explained to the patient or his/her representative:

- The diagnosis, nature and purpose of the transfusion.
- The risk and benefits of the transfusion.
- The patient's prognosis if the proposed treatment is not given.

I or my physician associate has given the patient or his/her authorized representative the opportunity to ask questions, and believe all questions have been answered to the patient and/or his/her representative's satisfaction.

Date	Time	Signature of Physician:

Eaton Rapids
Medical Center
517.663.2671 • www.eatonrapidsmedicalcenter.org
1500 South Main • Eaton Rapids, MI 48827

Patient First and Last Name:

Date of Birth:

Outpatient Transfusion Orders

Unless otherwise clearly specified hereon in writing, any orders for a drug identified below by its proprietary name, may be filled with its formulary identical

Ordering Physician: _____ Contact Number: _____
Diagnosis: _____Diagnosis Code: _____
Height: _____Weight: _____
Allergies: _____

Obtain Consent for Transfusion of Blood Component(s) ordered below
Laboratory results pertinent to Transfusion and date obtained: Hgb/HCT-_____ Date-_____
Platelet-_____ Date-_____Other-_____ Date-_____
Type and Screen, Crossmatch as required and give:
___Unit(s) Leukocyte Reduced Packed Red Blood Cells **(Check if required)** ☐CMV sero-negative ☐Irradiated
___Unit(s) Apheresis Platelets **(Check if required)** ☐CMV sero-negative ☐Irradiated
___Unit(s) Fresh Frozen Plasma _____
___Unit(s) Cryoprecipitate _____
___Unit(s) Factor VIII _____
___Other: _____

Check box or specify below:

- ☐ Initiate 18gauge or 20gauge IV _____
- ☐ Access PICC or Port for transfusion and flush per protocol
- ☐ 0.9 Normal Saline IV fluid with appropriate blood/blood component infusion set
- ☐ Diet: _____
- ☐ Activity:_____
- ☐ H&H one hour post-Leukocyte Reduced Packed Red Blood Cell transfusion
- ☐ Platelet count one hour post-Platelet transfusion
- ☐ Medications:_____
  _____
  _____

Discharge when the following criteria are met:

- ☐ Discharge patient after post-transfusion H&H or post-platelet labs are drawn
- ☐ Discharge patient after post-transfusion H&H or post-platelet results are obtained
- ☐ Discharge patient after post-transfusion H&H or post-platelet results are discussed with physician
- ☐ Other: _____

Above orders and Provider acknowledgement of <u>Informed Consent</u> for Blood and or Blood Component Administration

By signing this form, I certify that I or my physician associate has explained to the patient or his/her representative:

- The diagnosis, nature and purpose of the transfusion.
- The risks and benefits of the transfusion.
- The patient's prognosis if the proposed treatment is not given.

I or my physician associate has given the patient or his/her authorized representative the opportunity to ask questions, and believe all questions have been answered to the patient and/or his/her representative's satisfaction.

Date: _____ Time: _____ Signature of Physician: _____

Fax signed orders to 517-663-8615
After 4 p.m. or on weekends fax to 517-663-9436