

**BLOOD TRANSFUSION  
INFORMED CONSENT**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

Consent-E  
General Informed Consent



IDN13150039

1. I hereby authorize Rush University Medical Center to administer a transfusion of blood or blood products to the patient/myself as may be considered necessary or advisable during the patient's/my hospitalization.
2. I understand that the indication for the proposed transfusion is because the patient has a medical need for the blood or blood products.
3. I understand the nature of the proposed blood transfusion, and I understand that blood is given in a vein, most commonly in the arm, through sterile, single use tubing.
4. I understand the potential benefits of a blood transfusion may include one or more of the following: increased oxygen supply to the body, maintenance of blood pressure, improvement of blood flow, and sustaining of life. For patients with clotting disorders, transfusion of platelets, plasma, and/or other blood products may prevent or reduce abnormal bleeding.
5. I understand that there are possible risks of a transfusion.

Common risks may include one or more of the following: fever, rash, headache, and a slight bruise or local reaction in the area where the transfusion enters the vein.

Other more serious risks are rare and may include the following: serious allergic reactions, bacterial infections, or viral infections like Transfusion-Associated Viral Hepatitis (TAVH) a viral infection of the liver, and Human Immunodeficiency Virus (HIV), a virus known to cause Acquired Immunodeficiency Syndrome (AIDS). I understand that the risk of acquiring an infectious disease from transfused blood is low because blood units are laboratory tested for infectious agents such as TAVH and HIV as required by law; however, these laboratory tests are not foolproof.

6. I understand there is no effective alternative to transfusion if a medical need for blood or blood products poses a serious threat in the course of treatment.
7. I understand the possible consequences of refusing a transfusion may result in suffering serious injury, illness and/or death.
8. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or the consequences of the blood transfusion.
9. I acknowledge that I have read/had read to me the above information, that I fully understand this information, and that if I have questions I have had the opportunity to have them answered by the physician/health care provider.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Consenting Party*

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Print Name*

(OVER)

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INFORMED CONSENT**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

**Place Patient Label**

**WITNESS TO SIGNATURE OF CONSENTING PARTY:**

**IF CONSENTING PARTY IS OTHER THAN PATIENT:**

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Signature of Consenting Party*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Print Name* *Relationship*

**INFORMED CONSENT AFFIRMATION**

My signature below affirms that prior to the time of the procedure, I provided to the patient and/or his/her guardian the information verbally, by means of an information sheet and/or other audio/visual means of communication.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Licensed Health Care Provider*

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Print Name*

**TELEPHONE CONSENT**

Verbal authorization for the procedure(s)/treatment(s) was obtained from the consenting party named below who has stated that he/she has authority to consent on behalf of the patient following an explanation of the information above.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Print Name of Consenting Party*

Time: \_\_\_\_\_ A.M. / P.M.

\_\_\_\_\_  
*Relationship to Patient*

**WITNESS AND RECIPIENT OF CONSENT:**

\_\_\_\_\_  
*Signature of Witness*

**INSTRUCTIONS:** This consent form should be signed by the patient if an adult (18 years and older), by a parent or court-appointed guardian if the patient is a minor or by a court-appointed guardian if the patient has been declared legally incompetent.