


# Transfusion Consent New Version

**APPLIES TO ALL OUTPATIENT AND INPATIENT LOCATIONS AT BOTH CAMPUSES**

 **UPSTATE**  
UNIVERSITY HOSPITAL

**CONSENT TO TRANSFUSE**

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_  
Account #: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Diagnosis/Procedure: \_\_\_\_\_

Valid for ☐ Hospitalization  
☐ Estimated dates of treatment: From \_\_\_\_\_ (date) to \_\_\_\_\_ (date)  
☐ Outpatient: For length of treatment starting \_\_\_\_\_ (date). Valid for length of treatment, up to one year.  
• New consent must be signed if treatment is more than one year.

**During your treatment, you may need transfusions of blood products and/or derivatives for these reasons:**

- Anemia (low red cell count), thrombocytopenia (low platelet count), and leukopenia (low white blood cell count) can happen as a result of your health issue and/or its treatment. Correction of anemia with red cell transfusions, correction of thrombocytopenia with platelet transfusions, and correction of leukopenia with white blood cell transfusions may be needed.
- Decreased blood factors can happen as a result of your health issue and/or its treatment. Replacement of these factors by transfusions of blood plasma products/derivatives may be needed.

**The risks of blood transfusions are as follows:**

- Infections such as hepatitis and HIV (AIDS) which are very rare.
- Other problems such as transfusion reactions (fever, anxiety, chills, and discomfort) and changes in immunity may happen. They are more likely to occur with many transfusions.

I have read and understand the above information. My physician has explained the risks and benefits of blood transfusions and answered my questions.

☐ **Full Acceptance of Blood Products/Derivatives**

I agree to allow trained members of the hospital staff to transfuse any blood product/derivative deemed medically needed.

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_ Print Name \_\_\_\_\_

☐ **Partial Acceptance of Blood Products/Derivatives**

I agree to allow authorized members of the hospital staff to transfuse any blood product/derivative deemed medically necessary.

☐ Red blood cell (RBCs) ☐ Albumin ☐ Clotting factor concentrates  
☐ Platelets ☐ RhIG ☐ White blood cells & granulocytes  
☐ Plasma ☐ IVIG  
☐ Cryoprecipitate

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_ Print Name \_\_\_\_\_

**Consent Form Witness:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Witness \_\_\_\_\_ Print Name \_\_\_\_\_

I have discussed the treatment described above with the patient or relative whose signature appears on this document.

**Person Explaining Procedure:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_ Print Name \_\_\_\_\_

**CROSS OUT ANY OF THE ABOVE PARAGRAPHS THAT DO NOT APPLY AND INITIAL**

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- The current **Transfusion Consent (Form # 41485)** allows for documentation of acceptance of all blood products/derivatives **or** refusal of all blood products/derivatives
- Some patients are willing to accept transfusion of some, but not all blood products/derivatives
- Starting **August 1<sup>st</sup> 2024**, a new version of the Transfusion Consent will replace the current version which gives patients the agency to accept transfusion of **all** blood products/derivatives, **some** blood products/derivative (and specify which ones), or **no** blood products/derivatives
- Of note – the **Declination to Transfuse** is now on the **back** of the 1-page form

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UNIVERSITY HOSPITAL

**DECLINATION TO TRANSFUSE**

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_  
Account #: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

☐ **Refusal of All Blood Products / Derivatives**

The dangers of not having the recommended transfusion have been explained to me. Risks of not getting a transfusion could be bleeding that will not stop, anemia, organ failure, and death.

I bear the risks and possible results of refusal to consent to the transfusion(s), and I release all physicians who have been consulted in my case, the hospital, and its staff from liability and damages for any ill effects that may result from not being transfused.

I do not consent to have a transfusion of any blood products or derivatives.

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_ Print Name \_\_\_\_\_

**Consent Form Witness:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Witness \_\_\_\_\_ Print Name \_\_\_\_\_

I have discussed the treatment described above with the patient or relative whose signature appears on this document.

**Person Explaining Procedure:**

Date \_\_\_\_\_ Time \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_ Print Name \_\_\_\_\_

- Use of this new consent version will provide for better coordination of the clinical care team in compliance with the patient's wishes
- Utilization of this new version will require the clinical team to refer to the consent **prior** to transfusion/infusion to ensure that the patient has given consent for that blood product/derivative

**Contact Blood Bank for further information: 315-464-6701**