

University of
at
**REQUEST FOR BLOOD TRANSFUSION AND
CONSENT TO TRANSFUSION**

Date:

Time:

1. I hereby request and authorize the University of _____, through its physicians and employees, to administer blood or blood components to me through transfusion, whenever deemed necessary by my attending physician, Dr. _____
2. I have been informed by Dr. _____ that the blood or blood components which may be transfused to me might transmit various infectious agents including, but not limited to, cytomegalovirus, hepatitis viruses (including hepatitis B and C), infectious mononucleosis virus, retroviruses, including HIV-1/2 (which causes AIDS), and others, including various bacteria.
I have also been informed that in addition to performing all required tests, Blood Banks are evaluating investigational tests that may further reduce the risks of blood transfusion in the future. These tests will not affect the safety of blood components that are available for transfusion now.
I have been further informed that the transfusion of blood containing any of these infectious agents may result in my suffering from one of these diseases. The above risks exist despite the careful screening of blood donors and testing of the blood.
 Check here for Chronic Transfusion Therapy
In addition to the above potential adverse effects to transfusion therapy, I have been informed that I shall receive numerous transfusions over a period of time and that these can lead to other increased risks. These risks include, but are not limited to: 1) danger of infection, especially by viruses; 2) cumulative risk of iron overload with its potential complications, even death; 3) increased risks of immunization to blood group antigens; 4) possible detrimental effects, still undefined, to the immune system.
3. It has been explained to me that blood transfusions are not always successful in producing a desirable result. Also, other undesirable effects may complicate blood transfusion, including, but not limited to, chills, fever, itchiness or other mild allergic reactions, headache or pain elsewhere, blood incompatibility or (in rare instances) even death.
4. Alternatives to receiving blood from the voluntary blood supply have been presented to me, such as autologous transfusion (collection of my own blood for return to me) and directed donation (blood donation from family or friends to be used specifically for me). I understand that these alternatives may not be appropriate or available in all circumstances. In addition, the risks of not receiving transfusion have been discussed with me.
5. I understand that blood supplied to me is incidental to providing me services and that no guarantee can be made as to the quality of the blood provided.
6. I hereby request and consent to any needed blood component transfusion during my treatment at the University of Illinois Hospital.

SIGNATURE OF PATIENT (OR PERSON AUTHORIZED TO CONSENT FOR PATIENT)

SIGNATURE OF WITNESS

I certify that I personally explained the above risks and benefits to the patient and obtained his/her consent.

SIGNATURE OF PHYSICIAN OBTAINING CONSENT

MD

DATE

TIME

REFUSAL TO CONSENT TO TRANSFUSION

Understanding the nature of my condition, the reasons for and risks of blood transfusion, and alternative methods of treatment including those not involving transfusion, I have decided to withhold consent for the administration of blood components. I realize I may revoke my refusal at any time and thereafter consent to the receipt of such blood components, under the conditions specified in the above form.

DATE

TIME

SIGNATURE OF PATIENT (OR PERSON AUTHORIZED TO CONSENT FOR PATIENT)

SIGNATURE OF PHYSICIAN WHO DISCUSSED THE PROCEDURE WITH PATIENT
(OR PERSON AUTHORIZED TO CONSENT FOR PATIENT)

MD

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(REV. 6/99)