1. I, PATIENTS NAME ______ refuse the administration of blood and/or blood derivatives. I understand that such refusal may result in complications and ultimately even death.

The reason for my refusal is

2. I recognize this decision is my own. i have not been influenced or persuaded by anyone with regard to my decision to refuse blood transfusions.

I am ______ years old.

3. I hereby release The University Hospital, its physicians, employees and agents as well as any private attending physicians involved with my care from any claims arising out of the refusal to permit administration of blood or blood derivatives.

4. I understand that it is the considered opinion of the qualified health professional(s) attending me whose signature(s) appear below, that I will likely need blood and/or blood derivatives and understand the consequence of my refusal.

5. I acknowledge I have read this document in its entirety and fully understand it prior to my signing.

SIGNATURE OF PATIENT	DATE

WITNESS TO SIGNATURE	DATE

SIGNATURE OF NEAREST RELATIVE	SIGNATURE OF HEALTH PROFESSIONAL

Patient Label

REFUSAL OF BLOOD TRANSFUSION