



Consent for Blood Product Transfusion

FAX to HIM at 513-636-0744

Before agreeing to a blood product transfusion for me/my child, it is important that I discuss the needs, risks and benefits with my/my child's physician. For more information, I have been given a pamphlet that discusses these items and choices other than blood product transfusions. I understand that no guarantee or promise can be made regarding the results of the transfusion therapy. I understand that in an emergency situation, the person caring for me/my child may have to give blood products immediately without my express permission. I understand that this consent only covers blood products from the CCHMC Blood Bank.

I, _____ voluntarily consent for me/my child _____
Parent/Patient/Legal Guardian Name Age

to receive blood product transfusion therapy as part of the treatment of my/my child's disease or surgical condition as described below:

RIGHT TO REFUSE: I understand that I am free to refuse a transfusion. However, I understand that I should first discuss this with my physician and my family and look into the other choices.

SIGNATURES: By signing this consent form I am giving permission for transfusion of blood products:

Until the date of ____/____/____ (Unless otherwise noted, this consent will expire one year from the date of patient/parent/legal guardian signature) for the medical condition described above.

I understand that I may remove my consent at any time. I am aware that I should always discuss any planned transfusion with the physician ordering the transfusion and/or my/my child's physician to be sure that I understand the need for the transfusion. I have had the chance to ask questions. By signing, I confirm to the best of my knowledge that the law allows me to consent to the procedure(s) for this patient.

Patient/Parent/Legal Guardian has received: [] Neonates Risk and Benefit Pamphlet [] Standard Risk and Benefit Pamphlet

Patient/Parent/Legal Guardian Signature Time Date

Witness Signature Print Name Time Date Phone/Pager #

[] Parent/Legal Guardian was not physically present. Consent via telephone was obtained per policy.

Name of [] Parent [] Legal Guardian, specify: _____ Identity confirmed: [] Yes [] No

Telephone number: (____) _____ Date: ____/____/____ Time: _____

Comments: _____

Caller Signature/Title Caller Printed Name Time/Date

Witness Signature/Title Witness Printed Name Time/Date

PHYSICIAN: I understand that consent has not yet been obtained from the parents/legal guardian for this patient. I believe that treatment is medically necessary at this time in order to avoid risk to his/her well-being or to contribute to the worsening of his/her condition.

Physician Signature/Credentials: _____ Time/Date: _____ Pager #: _____

Upon completion, fax to HIM at 513 - 636 - 0744

Confirmation: Form faxed by: _____ Time/Date: _____

