Refusal or Limited Consent for Transfusion of Blood Components and/or Blood Products

I _____have been informed by my physician or authorized health professional _____ , that in the course of my medical/surgical treatment I may need a transfusion of blood components and/or blood products. The nature, purpose and effects of the components and/or products have been described to me.

I have been informed of and understand the benefits and risks associated with receiving this therapy.

The above mentioned professional and I have discussed the risks, including death, of not receiving a blood transfusion. We have discussed the possibility of using alternative treatments other than a blood transfusion. I understand the benefits and risks of these alternative treatments, including the risks of not receiving a blood transfusion.

Having been informed of the benefits and risks of consenting to or refusing this treatment, I direct as follows (Initial only one):

Refusal:

☐ I direct that NO BLOOD TRANSFUSIONS (whole blood, red blood cells, white blood cells, platelets, plasma, blood products) are to be given to me under any circumstances, even if such treatment may, in the opinion of the attending physician and/or surgeon or his/her assistants be deemed necessary to save my life or promote my recovery.

OR

Limited Consent:

☐ I direct that NO BLOOD TRANSFUSIONS (whole blood, red blood cells, white blood cells, platelets, plasma, and blood products) are to be given to me under any circumstances, **except** where in the opinion of the attending physician and/or surgeon or his/her assistants are **deemed necessary to save my life**. I have indicated my consent to such treatments by placing my initials in the associated consent box in the following table:

Blood, Blood Component and/or Blood Product	**YES, I consent to the use of the following treatment(s) where it is deemed necessary to save my life:**
Whole Blood / Red Cells	
Platelets	
Plasma	
Cryoprecipitate	
Blood product (specify):	

I hereby release the attending physician and/or surgeon, his/her assistants, (District Health Authority/Facility), and its officers, agents, employees and representatives from any responsibility whatsoever for any adverse results, including death, which may result from my refusal to permit the use of blood components or blood product transfusions.

I have read (or the document has been read to me) and understand what has been discussed.

_____ **Date:**_____
Signature of patient

Or

_____ **Date:**_____
Signature of Substitute Decision Maker

Substitute Decision Maker (Print Name):_____

Nature of Relationship to Patient: _____

STATEMENT OF TREATING PHYSICIAN OR AUTHORIZED HEALTH PROFESSIONAL

I confirm that I have explained the nature, associated benefits, potential risks, and likely consequences of consenting to or refusing the transfusion of blood components or blood products and alternative therapies and provided an opportunity to ask questions and answered all questions that were asked.

Signature of Physician or Authorized Health Professional

_____ **CPSNS#**_____

PRINT NAME_____ **Date:**_____