WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

HDGH
ESTD 1888

Erie Shores HealthCare
COMPASSIONATE CARE CLOSE TO HOME

ADDRESSOGRAPH

C O N S – O T H

CONSENT FOR THE ADMINISTRATION OF BLOOD AND/OR BLOOD PRODUCTS

I, understand it may be necessary for _____ to receive a blood or blood product(s) for one of the reasons listed below. I understand what blood products are and how they are given. These blood products may include but are not limited to:

⇒ **Platelets to help my blood clot and prevent bleeding**
⇒ **Red Blood Cells to correct anemia, to increase the oxygen delivery to my body**
⇒ **Plasma to help clot my blood**

I have read/or been provided with information regarding the administration of blood or blood products.

The Decision-Maker and Physician/Health Care Practitioner have discussed the following:

- The risks and benefits of receiving a blood product. I understand that risks exist even though the blood/blood product has been tested. I understand, that in receiving a blood product, there are risks of which we are unaware and I may potentially be exposed to risk, which is not possible to identify at present.
- The alternatives to blood transfusion and the use of my own blood (Autologous) as an alternative to allogeneic (donated) transfusion. Even if my own blood is used, it may sometimes be necessary to give additional blood/blood products donated by others. I understand the benefits and risks of these alternatives.
- I understand the risks of not receiving a blood product.

The Decision-Maker requests and consents to the following:

- The administration of blood/blood products donated by volunteer blood donors collected at blood centers (e.g. Canadian Blood Services) and that the hospitals represented above and its staff and agents have taken necessary precautions in storing blood products and preparing them for administration.

Signature of Patient: _____ **OR** Signature of Substitute Decision Maker**:** _____

Name of Substitute Decision Maker (*please print*):_____ Relationship:_____

Signature of Physician/Health Care Practitioner:_____ Date:_____ Time:_____

Signature of Witness for Telephone Consent:_____ Date:_____ Time:_____

EMERGENCY BLOOD/BLOOD PRODUCT ADMINISTRATION - PHYSICIAN STATEMENT

I certify that, due to the urgent need for blood/blood product administration, I have been unable to obtain informed consent for blood/ blood products prior to therapy and I have no advanced directive indicating that the administration in reasonable circumstances is rejected. As mandated in the HEALTH CARE CONSENT ACT, Section 25.5, the physician must promptly note on the patient's health care record the opinions that are held by the physician on which he or she relied.

Physician Signature: _____ Date: _____

Physician Name:_____ Time: _____
(Please Print)

A COPY OF THE CONSENT FORM MUST APPEAR ON THE PATIENT'S HOSPITAL CHART

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N O – B L O O D

EXCEPTIONS TO CONSENT FOR BLOOD AND/OR BLOOD PRODUCTS

Part A. REFUSAL OF **ALL** BLOOD AND/OR BLOOD PRODUCTS

I request that no blood or blood products be administered to _____ during this hospitalization.
(Patient's Name - please print)

I hereby release the hospitals represented above, its personnel, and the attending Physician(s) from any untoward results due to my/this refusal to administer blood or blood products and I fully understand the possible consequences of such refusal on my part.

Signature of Patient: _____ **OR** Signature of Substitute Decision Maker**:** _____

Name of Substitute Decision Maker (*please print*):_____ Relationship:_____

Signature of Physician/Health Care Practitioner:_____ Date:_____ Time:_____

Part B. LIMITATIONS TO THE USE OF BLOOD AND/OR BLOOD PRODUCTS

I _____ have had explained to me by Dr. _____
(Patient's Name - please print) *(Physician's Name - please print)*

on _____ that it may be necessary to receive blood and/or blood products.
(Date)

I understand the risks of not having a blood product.

I do not accept any blood and/or blood products except (please specify) _____.

I hereby release the hospitals represented above, its personnel, and the attending Physician(s) from any untoward results due to my/this refusal to administer blood and/or blood products except those mentioned above and I fully understand the possible consequences of such refusal on my part.

Signature of Patient: _____ **OR** Signature of Substitute Decision Maker**:** _____

Name of Substitute Decision Maker (*please print*):_____ Relationship:_____

Signature of Physician/Health Care Practitioner:_____ Date:_____ Time:_____

Part C. REVOKAL of REFUSAL for ALL / SOME BLOOD AND/OR BLOOD PRODUCTS

If this section is completed, please ensure Consent for Transfusion (over) is completed.

I _____ hereby revoke the above-signed refusal of all/some blood and/or blood products.
(Patient's Name - please print)

Signature of Patient: _____ **OR** Signature of Substitute Decision Maker**:** _____

Name of Substitute Decision Maker (*please print*):_____ Relationship:_____

Signature of Physician/Health Care Practitioner:_____ Date:_____ Time:_____

TRANSLATOR INVOLVED IN OBTAINING CONSENT

I, _____ have, to the best of my ability, translated the treatment information provided by the
(Name or ID # of the Translator - please print)

physician, to _____
(Patient's Name - please print)

Translator Signature: _____ Date: _____ Time:_____

Witness Signature - If Translation by Telephone: _____ Date: _____ Time:_____