Facility: Elmhurst Hospital Center

NYC HEALTH+ HOSPITALS

Chart No.

Name

Unit

(Patient Imprint Card)

CONSENTIMIENTO INFORMADO PARA TRANSFUSIÓN DE SANGRE Y PRODUCTOS SANGUÍNEOS / INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS

FORM B-3

Para ser usado por pacientes que reciben transfusiones en el marco de su tratamiento médico, sin ser parte de un procedimiento invasivo, diagnóstico, médico o quirúrgico. / To be used for patients receiving transfusion(s) as their medical treatment, which is not part of an invasive diagnostic, medical or surgical procedure.

_____ (nombre de los médicos tratantes o de los proveedores de atención médica autorizados / Name of Attending Physician[s] or Authorized Health Care Provider[s]) me ha informado de los riesgos, los beneficios y las alternativas disponibles de la transfusión de sangre y productos sanguíneos.

Me han explicado que, a pesar de que por ley deben estudiarse toda la sangre y los productos sanguíneos para detectar la presencia de agentes infecciosos potencialmente transmisibles, incluidos los que son conocidos por causar SIDA, hepatitis y sífilis, no es posible eliminar por completo la transmisión potencial de toda enfermedad nociva, pero el riesgo para mí es mínimo.

También entiendo que en raras ocasiones se producen reacciones a las transfusiones que pueden ocasionar dificultades para respirar, fiebre, dolores, escalofríos, náuseas, ictericia, daño renal, trastornos de coagulación, anemia, insuficiencia cardíaca e incluso la muerte.

Me han dado la oportunidad de hacer preguntas sobre mi afección y la necesidad de ser transfundido, incluidas terapias alternativas, y considero que he recibido información suficiente para tomar esta decisión informada. Consiento la administración de sangre y productos sanguíneos.

		y/and		**a. m./am**
Firma del paciente o del padre/la madre/el tutor legal del paciente menor de edad / Signature of Patient or Parent/Legal Guardian of Minor Patient	**Fecha/Date**		**Hora/Time**	**p. m./pm**

If the patient cannot consent for themself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

		y/and		**a. m./am**
Firma del representante de atención médica/el tutor legal / Signature of Health Care Agent/Legal Guardian	**Fecha/Date**		**Hora/Time**	**p. m./pm**

(Place a copy of the authorizing document in the medical record)

		y/and		**a. m./am**
Firma y vínculo del sustituto / Signature and Relation of Surrogate	**Fecha/Date**		**Hora/Time**	**p. m./pm**

WITNESS:

I, _____ , am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient, or an authorized representative, voluntarily sign this form ☐; **OR** consent to treatment telephonically ☐ **. (Check one box.)**

I, _____ , am a staff member who is not the patient's physician or authorized health care provider and I have witnessed that the patient is **unable** to sign this form ☐; **OR** that the patient or an authorized representative, **refused** to sign this form ☐. **(Check one box.)**

		and		**am**
Signature and Title of Witness	**Date**		**Time**	**pm**

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)

I have provided an accurate and complete interpretation of an explanation/discussion of this form between the health care provider(s) and the patient or the patient's authorized representative.

		and		**am**
Signature of Interpreter (if present), ID# and Agency Name	**Date**		**Time**	**pm**

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INFORMED CONSENT PROGRESS NOTE

(The Informed Consent Form HH 100 B-3 on the reverse side must also be completed)

I explained the risks, benefits, side effects and alternatives of the proposed transfusion of blood and blood products to the above named patient for treatment of Anemia (Identify Diagnosis).

As I explained to the patient, the risks, benefits, side effects, alternatives, intended goals and likelihood of success of the transfusion to achieving healthcare goals (including potential problems with recuperation) include but are not limited to:

Risks and side effects of the proposed care: allergic reactions, respiratory distress, lung injury, transfusion related circulatory overload, infections including HIV and hepatitis, effects on immune system, significant morbidity, death

Benefits: correction of anemia

Alternatives (including the risks, side effects and benefits thereof): no transfusion

Risks of not receiving this blood and blood product: continued or worsening symptoms, significant morbidity, organ injury, cardiac arrest, death

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider* **Date** **and** **Time** **am** **pm**

Print Name and License Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING PHYSICIAN'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has consented to the proposed treatment for the patient, the surrogate has signed the consent form.

Signature of the Attending Physician **Date** **and** **Time** **am** **pm**

Print Name and License Number

*Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent.