Facility: Elmhurst Hospital Center

NYC HEALTH+ HOSPITALS

INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS

Chart No.

Name

Unit

(Patient Imprint Card)

FORM B-3

To be used for patients receiving transfusion(s) as their medical treatment, which is not part of an invasive diagnostic, medical or surgical procedure.

I have been informed by_____ (Name of Attending Physician[s] or Authorized Health Care Provider[s]) of the risks, benefits and available alternatives to transfusion with blood and blood products.

It has been explained to me that although all blood and blood products by law are tested for the presence of potentially transmissible infectious agents including those known to cause AIDS, Hepatitis and Syphilis, it is not possible to completely eliminate the potential transmission of every harmful disease but the risk to me is minimal.

I also understand that on rare occasions transfusion reactions occur and may result in difficulty breathing, fever, pain, chills, nausea, jaundice, kidney damage, clotting disorders, anemia, heart failure and even death.

I have been given an opportunity to ask questions about my condition and the need to be transfused including alternative forms of therapy and I believe that I have received sufficient information to make this informed decision. I consent to the administration of blood and blood products.

_____ _____ **and** _____ **am**

Signature of Patient or Parent/Legal Guardian of Minor Patient **Date** **Time** **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.

_____ _____ **and** _____ **am**

Signature of Health Care Agent/Legal Guardian **Date** **Time** **pm**

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

_____ _____ **and** _____ **am**

Signature and Relation of Surrogate **Date** **Time** **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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Chart No.

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INFORMED CONSENT PROGRESS NOTE

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

Name

Unit

(Patient Imprint Card)

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.