Vellum

BLOOD TRANSFUSION CONSENT FORM

Facility: ____

Patient Name (Printed) : ____

Patient DOB : ________________________________

Authorization: I hereby authorize Dr. ____
or his/her designee, as well as any other physicians or allied health professionals deemed necessary, to administer blood and/or blood products transfusion(s) to me. I understand, in general terms, what a blood transfusion entails and the procedures that will be utilized. I understand that my physician or designee will determine the type and quantity of blood product required based on my individual clinical needs to stabilize my condition or preserve my life.

Explanation and Benefits: The nature, purpose, and potential benefits of the proposed transfusion have been explained to me. I understand that transfusion is intended to treat my medical condition and I acknowledge the potential consequences of not receiving the transfusion. I have considered the risks and benefits and have decided that the expected benefits outweigh the potential risks.

Risks and Potential Complications: I understand that all medical procedures, including blood and blood product transfusions, carry inherent risks. While many transfusion reactions are mild and treatable, serious complications may occur. I acknowledge that, in addition to commonly known and reasonably foreseeable risks, there may be other risks and complications that cannot be fully anticipated or specifically identified.

Potential risks and complications include, but are not limited to:

- Itching, rash, hives, or other allergic reactions
- Fever, chills, shaking, or flushing
- Nausea or vomiting
- Pain or discomfort
- Hemolytic transfusion reaction
- Severe allergic or anaphylactic reaction
- Abnormal blood clotting or bleeding complications
- Respiratory complications, including shortness of breath or transfusion-related acute lung injury (TRALI)

I understand that severe or life-threatening transfusion reactions, although rare, may result in serious injury, organ dysfunction, permanent disability, or death. In the event of a serious transfusion reaction occurring within the nursing home or non-hospital setting, emergency medical interventions will be initiated immediately, including activation of Emergency Medical Services (EMS) and transfer to a higher level of care when clinically indicated.

Voluntary Consent: I have had the opportunity to ask questions regarding this transfusion, its risks, benefits, and alternatives. I understand that my consent is voluntary and may be withdrawn at any time prior to the procedure.

Acknowledgment and Signature

By signing below, I voluntarily consent to the administration of blood and/or blood products as indicated by my physician and performed by qualified healthcare personnel in this nursing home setting.

Printed Name of Patient or Legal Representative:

____

Signature of Patient or Legal Representative :

_______________________________ Date/Time: ______________________

Relationship to Patient (if not patient): ______________________________

Printed Name of Witness (Healthcare Professional):

____

Witness Signature (Healthcare Professional):

_______________________________ Date/Time: ______________________

If Telephone Consent Obtained

Printed Name of Witness (Healthcare Professional):

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Witness Signature (Healthcare Professional) :

_______________________________ Date/Time: ______________________

Physician Certification: *I have explained the nature, anticipated benefits, potential risks, and alternatives of the transfusion to the patient or legal representative, and all questions have been addressed.*

Physician Name: ________________________**Date/Time:** ______________________

Legal Reference: *This consent form complies with Texas Health & Safety Code §164.052 regarding informed consent for medical procedures.*