UMC HEALTH SYSTEM

UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

DISCLOSURE AND CONSENT –BLOOD/BLOOD COMPONENT TRANSFUSION

I acknowledge that I have been informed by___________________________Title ____________________ of UMC Health System, that I may need a transfusion (s) of blood (or one or more of its components) during the course of my medical treatment here. Despite the fact that the blood (or one or more of its components) has been carefully tested, the possibility of risk remains. These risks include, but not limited to:

A. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.

B. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys and immune system.

C. Severe allergic reaction, potentially fatal.

The medical needs for transfusion(s) and the alternatives to transfusion(s), including the risks and consequences of not receiving this therapy have been explained to me.

I have had the opportunity to ask questions, and I consent to the transfusions(s).

_____________ ____________A.M. (P.M.)
Date Time

____
*****Patient/Other legally responsible person signature Relationship (if other than patient)

____
*Witness Signature Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415 ☐ TTUHSC 3601 4th Street, Lubbock, TX 79430
☐ UMC Health & Wellness Hospital 11011 Slide Road, Lubbock TX 79424
☐ OTHER Address: ____
Address (Street or P.O. Box) City, State, Zip Code

****

INFORMED REFUSAL FOR BLOOD/BLOOD COMPONENT TRANSFUSION(S)

The risks have been explained to me, and I choose to refuse transfusion(s) at this time for the following reason(s):

____

____

_____________ ____________A.M. (P.M.)
Date Time

____
*****Patient/Other legally responsible person signature Relationship (if other than patient)

____
*Witness Signature Printed Name

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Resident and Nurse Consent Checklist

Consent may not contain blanks

Section 1:	Enter name of physician or nurse providing explanation for blood and/or blood product administration.
Section 2:	Discuss risks with patient.
Patient Signature:	Enter date and time patient or responsible person signed consent.
Witness Signature:	Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature

If the patient does **not** consent to (refuses) blood or blood product transfusion, the refusal consent and appropriate signatures must be obtained.

For additional information on informed consent policies, refer to policy SPP PC-17.

Nurse_____Resident_____Department _____

THIS FORM IS NOT PART OF THE MEDICAL RECORD