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| **Consent Form for the Refusal of Blood Transfusion** |

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| **Patient Details** (or pre-printed label) |
| Patient Surname/ family name |
| Date Of Birth | Male |  | Female |  |
| CHI: |

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| This part to be completed by a Registered Medical Practitioner  |
| Type Of Operation Investigation or Treatment: |
| A patient ‘agreement to investigation or treatment consent form’ has been completed, if no, please give reason why above | Yes |  | No |  |
| I acknowledge that this limited consent will not be over-ridden unless revoked or modified, this should be recorded in writing.  |
| **I am the**  | patient |  | parent |  | guardian |  |
| **I agree (subject to the exclusions below)**  | * To what is proposed, which has been explained to me by the doctor named on this form
* To the use of the type of anaesthetic that I have been told about
* To the use of non-blood volume expanders; pharmaceuticals that control haemorrhage and/ or stimulate the production of red cells.
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| **I have told the doctor** **(tick as appropriate)** |  | That I am one of the Jehovah’s Witnesses with firm religious convictions |
|  | I am refusing blood for personal reasons |
| **I understand**  | That the procedure might not be done by the doctor who has been treating me so far. |
| **That my express refusal of allogeneic blood or primary blood components, as indicated on page two, will be regarded as absolute and will NOT be over-ridden in any circumstances by a purported consent of a relative or other person or body. Such refusal will be regarded as remaining in force even though I may be unconscious and/ or affected by medication/ stroke, or other condition rendering me incapable of expressing my wishes and consent to treatment options, and the doctors(s) treating me consider that SUCH REFUSAL MAY BE LIFE THREATENING.**  |
| That any procedure in addition to the investigation or treatment described on this form, but with the exclusion of the transfusion of allogenic blood or primary blood components, will only be carried out if necessary and in my best interests and can be justified for medical reasons.  |
| That details of my treatment, and any consequences resulting, will not be disclosed to any source without my express consent or that of my instructed agent(s) unless required by law.  |

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Please indicate your requirements by ticking appropriate boxes -:

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|  | **Accept** | **Refuse** |
| **Primary Blood Components**  |  |  |
| Red Blood cells  |  |  |
| Fresh Frozen Plasma (FFP, plasma) |  |  |
| Platelets  |  |  |
| White cells (Granulocytes)  |  |  |

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| **Products containing a minor blood fraction** |  |  |
| Cryoprecipitate |  |  |
| Albumin |  |  |
| Intravenous immunoglobulin |  |  |
| Anti-D immunoglobulin |  |  |
| Other immunoglobulins e.g. tetanus |  |  |
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| **Procedures involving my own blood** |  |  |
| Cell salvage |  |  |
| Acute normovolaemic haemodilution |  |  |
| Renal Dialysis |  |  |
| Plasmapheresis |  |  |
| Blood radio-labelling |  |  |
|  |  |  |
| **Recombinant products – not blood sourced** |  |  |
| rFVIIa (Novoseven) |  |  |
| Erythropoietin |  |  |
| Others e.g. FVIII |  |  |
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| **Other Components/Procedures****(please specify)** |  |  |

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| **Patient** |
| I confirm that I have indicated above my wishes. I accept or refuse the blood components & procedures as detailed above.Signature: Print name: Date: |
| **Doctor** |
| Signature: Print name: Date: |