

DISCLOSURE AND CONSENT
BLOOD AND BLOOD PRODUCTS

You have the right as a patient to be informed of the potential risk factors related to blood and/or blood products if you should need them during this hospital stay such as:

1. Fever
2. Transfusion reaction which may include kidney failure or anemia .
3. Heart failure
4. Hepatitis
5. A.I.D.S. (Acquired Immune Deficiency Syndrome)
6. Other infections

_____ I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedure to be used, and the risks and hazards involved.

_____ I do consent to the use of blood or blood products if it becomes necessary.

_____ I request autologous (patient's own) blood and any additional blood or blood products if necessary.

_____ I request autologous (patient's own) blood only. I request no other blood or blood products to be administered to me.

_____ The reason I am refusing such transfusion(s) is:

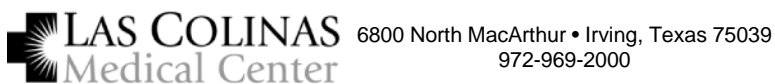
In doing so, I release Las Colinas Medical Center from any unfavorable reactions or any untoward results due to my refusal (shock, resulting in permanent brain, kidney, or liver damage; loss of limb; death) and I fully understand the possible consequences of such refusal on my part.

Date: _____

Time: _____ A.M./P.M.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE

WITNESS: _____
Name



**Consent Blood and Blood Products
Disclosure and Consent**



TREAT

PATIENT IDENTIFICATION