Facility: **Kings County Hospital Center**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Chart No.

Name

Unit

(Patient Imprint Card)

KONSANTMAN ENFÒME POU TRANSFIZYON SAN AK PWODUI SANGEN
(INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS)

FORM B-3

Itilize fòm sa a pou pasyan kap resevwa transfizyon kòm tretman medikal yo, e ki pa fè patide yon pwosedi dyagnostik anvayisan, medikal oswa chirijikal./To be used for patients receiving transfusion(s) as their medical treatment, which is not part of an invasive diagnostic, medical or surgical procedure.

_____ (Non Medsen Tretan an oswa Founisè ki Otorize Bay Swen Sante a/ **Name of Attending Physician or Authorized Health Care Provider**) enfòme m sou risk, avantaj ak lòt opsyon ki disponib konsènan transfizyon san ak pwodui sangen.

Yo esplike mwen ke byenke selon lalwa yo teste tout san ak pwodui sangen yo pou wè si yo gen ladan yo ajan enfektye ki ka transmisib ikonpri sa ki bay SIDA a, Epatit ak Sifilis, li pa posib pou elimine konplètman posibilite pou transmisyon tout maladi danjere yo, men risk pou m pran yo a minim.

Mwen konprann tou ke raman moun konn gen reyaksyon a transfizyon e sa ka koze difikilte pou respire, lafyèv, doulè, frison, noze, lajonis, domaj nan ren, twoub kowagilasyon, anemi, ensifizans kadyak e menm lanmò.

Yo te banm opòtinite pou m poze kesyon sou kondisyon m nan ak sou rezon ki fè mwen bezwen transfizyon an, ikonpri lòt fòm terapi ki genyen, e mwen kwè ke mwen resevwa ase enfòmasyon pou m sa pran desizyon enfòme sila a e mwen konsanti pou yo administre san ak pwodui sangen yo.

_____	_____ **ak** _____	**am**
Siyati pasyan an oswa paran/responsab legal pasyan ki se minè a **(Signature of Patient or Parent/Legal Guardian of Minor Patient)**	**Dat** **(Date)** **(and)** **Lè** **(Time)**	**pm**

If the patient cannot consent for him/herself, 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.

_____	_____ **ak** _____	**am**
Siyati reprezantan k ap pran desizyon sou swen sante a/ responsab legal la (Signature of Health Care Agent/Legal Guardian) **(Place a copy of the authorizing document in the medical record)**	**Dat** **(Date)** **(and)** **Lè** **(Time)**	**pm**
_____	_____ **ak** _____	**am**
Siyati ak relasyon de ranplasman **(Signature and Relation of Surrogate)**	**Dat** **(Date)** **(and)** **Lè** **(Time)**	**pm**

TEMWEN (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 other appropriate person voluntarily sign this form.

_____	_____ **ak** _____	**am**
Siyati ak tit temwen an (Signature and Title of Witness)	**Dat** **(Date)** **(and)** **Lè** **(Time)**	**pm**

ENTÈPRÈT/TRADIKTÈ (INTERPRETER/TRANSLATOR): (To be signed by the interpreter/translator if the patient required such assistance)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

_____	_____ **ak** _____	**am**
Siyati entèprèt la/tradiktè a (Signature of Interpreter/Translator)	**Dat** **(Date)** **(and)** **Lè** **(Time)**	**pm**

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INFORMED CONSENT PROGRESS NOTE

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

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 _____ (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: _____

_____

_____

Benefits: _____

_____

Alternatives (including risks, side effects and benefits thereof): _____

_____

Risks of not receiving this blood and blood product: _____

_____

_____

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.

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

Signature of Attending Physician or Authorized Health Care Provider* **Date** **Time** **pm**

_____

Print Name and Identification 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.

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

Signature of the Attending Physician **Date** **Time** **pm**

_____

Print Name and Identification 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. See also HHC Consent Policy, Article III.