Facility: **Kings County Hospital Center**

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

Chart No.

Name

Unit

(Patient Imprint Card)

INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS

FORM B-3

To be used for patients receiving transfusion(s) as their medical treatment, which is not part of an invasive diagnostic, medical or surgical procedure.

I have been informed by_____ (Name of Attending Physician or Authorized Health Care Provider) of the risks, benefits and available alternatives to transfusion with blood and blood products.

It has been explained to me that although all blood and blood products by law are tested for the presence of potentially transmissible infectious agents including those known to cause AIDS, Hepatitis and Syphilis, it is not possible to completely eliminate the potential transmission of every harmful disease but the risk to me is minimal.

I also understand that on rare occasions transfusion reactions occur and may result in difficulty breathing, fever, pain, chills, nausea, jaundice, kidney damage, clotting disorders, anemia, heart failure and even death.

I have been given an opportunity to ask questions about my condition and the need to be transfused including alternative forms of therapy and I believe that I have received sufficient information to make this informed decision and I consent to the administration of blood and blood products.

Signature of Patient or Parent/Legal Guardian of Minor Patient	**Date**	**and**	**Time**	**am / 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.

Signature of Health Care Agent/Legal Guardian (Place a copy of the authorizing document in the medical record)	**Date**	**and**	**Time**	**am / pm**
Signature and Relation of Surrogate	**Date**	**and**	**Time**	**am / pm**

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.

Signature and Title of Witness	**Date**	**and**	**Time**	**am / pm**

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.

Signature of Interpreter/Translator	**Date**	**and**	**Time**	**am / 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: Allergic reactions, fever, chills, flushing, nausea, acute lung injury (1:2,500), hemolytic reactions (1:6000, 1:50,000 for fatal reaction), and infections including bacterial (1:50,000), HIV (< 1:2,000,000), Hepatitis B (1:200,000) and Hepatitis C (1:2,000,000).

Benefits: Improved medical condition. Red blood cells deliver oxygen to the tissues, platelets and plasma help stop bleeding and replace other substances needed in the blood. Other:

Alternatives (including risks, side effects and benefits thereof): Medications are available which can: 1. stimulate the bone marrow to make more blood cells, 2. treat bleeding disorders. Other:

Risks of not receiving this blood and blood product: Life threatening anemia and risk of complications that might result in death. Other:

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.