

Facility:

NYC Health+Hospitals -
Kings County

**NYC
HEALTH+
HOSPITALS**

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[s] or Authorized Health Care Provider[s]) 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. 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 themselves, 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 _____ **Date** and _____ **Time** **am**
(Place a copy of the authorizing document in the medical record) _____ **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 an authorized representative, voluntarily sign this form ☐ ; **OR** consent to treatment telephonically ☐ .
(Check one box.)

I, _____, am a staff member who is not the patient's physician or authorized health care provider and I have witnessed that the patient is **unable** to sign this form ☐ ; **OR** that the patient or an authorized representative, **refused** to sign this form ☐ . (Check one box.)

Signature and Title of Witness _____ **Date** and _____ **Time** **am**

pm

INTERPRETER: (To be signed by the interpreter if the patient required such assistance)

I have provided an accurate and complete interpretation of an explanation/discussion of this form between the health care provider(s) and the patient or the patient's authorized representative.

Signature of Interpreter (if present), ID# and Agency Name _____ **Date** and _____ **Time** **am**

pm

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INFORMED CONSENT PROGRESS NOTE

**(The Informed Consent Form HH 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 the 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.

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

Print Name and License 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.

Signature of the Attending Physician _____ and _____ am
Date Time pm

Print Name and License 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.