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Regional
REFUSAL OF BLOOD COMPONENT/PRODUCT ADMINISTRATION

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PATIENT SURNAME	FIRST NAME	Other names	DOB(d/m/yyyy)	CARE CARD #

Note: This refusal to consent to administration of blood components/products will remain valid only for the duration of the procedure/treatment course below.

Section 1: Patient Refusal

I, _____, refuse the administration of blood components/products during my health care procedure or treatment described below. I understand the risks of not receiving blood components/products.

In making my decision to refuse administration of blood components/products, I confirm the following:

1. Dr. _____ and I have discussed the risks, including death, of not receiving blood components/products during the following procedure or treatment (print in full without abbreviations):

   _____

   _____

   _____

2. I have been given oral and/or written information and was given the opportunity to ask questions about the benefits and risks of receiving blood components/products. I am satisfied that my questions have been adequately answered. I understand what I have read (or has been read to me), and what has been discussed.
3. My doctor and I have discussed the possibility of using treatments other than administration of blood components/products which are appropriate for me. I understand the benefits and risks of these alternative treatments.
4. I understand I have the right to change my mind at any time regarding this refusal. However, I also understand there may be circumstances where it might be impossible to communicate my decision to cancel this refusal (for example, if I am unconscious during surgery).
5. I have indicated the following special instructions:

   _____

   _____

   _____

Signature: _____ Date (d/m/yyyy): _____

☐ Patient ☐ Parent/Legal Guardian ☐ Substitute Decision Maker*

Note: If signed by Substitute Decision Maker, the Confirmation of Substitute Decision Maker form must be completed.

Section 2: Physician Statement

I have explained the benefits and risks of consent and refusal to administration of blood components/products with the above named patient or substitute decision maker.

Signature of Physician: _____ Date (d/m/yyyy): _____

Note: Original to be filed on patient's health record. Copy to be sent immediately to Transfusion Medicine Laboratory

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