I, _____, understand that transfusion of blood or blood components is, or may be, medically necessary for my care, or the care of _____ . My provider has explained the reason for the transfusion and any reasonable alternatives including no transfusion, autologous transfusion, and directed donor transfusion.
I understand there are risks of transfusion despite extensive testing which include, but are not limited to: Hepatitis B, Hepatitis C, rare viral, bacterial and parasitic infections, other rare diseases, allergic reaction, temperature elevation, circulatory overload and death. I have had the opportunity to ask questions about transfusion and my questions have been answered to my satisfaction.

☐ I consent to the administration of all blood and blood products

☐ I consent to the administration of only the following blood and blood products:

Blood Product	I accept	I refuse
Whole Blood	☐	☐
Major Fractions of Blood	☐	☐
Packed Red Blood Cells (RBCs, Erythrocytes)	☐	☐
White Blood Cells (WBCs, Leukocytes)	☐	☐
Platelets (Thrombocytes)	☐	☐
Fresh Frozen Plasma (FFP)	☐	☐
Fractions of Major Blood Fractions	☐	☐
Albumin	☐	☐
Tissue adhesives (Cryoprecipitates) Fibrinogen	☐	☐
Erythropoietin (contains 2.5 mg human albumin per mL)	☐	☐
Immune Globulin (blood fraction, Rhogam)	☐	☐
Hemophiliac preparation (clotting factors)	☐	☐
Autologous blood	☐	☐
Other (ENTER THE PRODUCT NAME HERE):	☐	☐

☐ I refuse all blood and blood products even if, in the opinion of my provider, they are medically necessary to prevent death or damage to tissues, organs or bodily functions. I understand that my health/the health of _____ may be negatively affected or death may result from this refusal. I release UPMC and all providers involved in my care and their respective employees, agents, and representatives, from liability for any damage that might be caused by my refusal of blood.

Patient_____ _____ _____ _____
Signature Date Time Witness of Signature Date Time

_____ _____ _____ _____ _____ _____ _____
Signature of Person Authorized to Consent for Patient Relationship Date Time Witness of Signature Date Time

PROVIDER'S CERTIFICATION

I hereby certify that the patient or person authorized to consent for the patient did so after having been advised orally as to the nature, purpose, benefits, risks of, alternative options (including no treatment), risks of alternative options, likelihood of achieving goals of care, potential problems that may occur, the matters referred to in the consent, and after having received answers to any questions. By signing below, I indicate that the patient or person authorized to consent fully understands what I have explained and answered.

Provider_____ _____ _____ _____
(Signature) *(Printed Name)* *(Date)* *(Time)*

UPMC LIFE CHANGING MEDICINE

INFORMED CONSENT (OR REFUSAL) FOR ADMINISTRATION OF BLOOD AND BLOOD COMPONENTS

PATIENT IDENTIFICATION