Plastic Surgery & Dermatology Associates (PSDA)

PATIENT CONSENT FOR TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

NAME:__________________________________
PERSONAL MD:____________________________
MD ADDRESS:_____________________________

1. I hereby consent to the administration of a transfusion of blood or blood products to

   ____
   (Name of Patient)

   and such additional transfusions as may be deemed advisable in the judgment of the attending physician, or his associates or assistants. This consent applies for the entire duration of the admission.

2. The reason for my needing blood or transfusion products and the role which these products play in the subsequent treatment of my disease has been adequately explained to me by my physician. Among these reasons is to decrease the risk of complications including, but not limited to, shock, heart failure, excessive bleeding and death.

3. I understand that the blood I will receive has been tested in accordance with regulatory requirements for the detection and prevention of the transmission of Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (the cause of AIDS), Human T cell lymphotropic virus and Syphilis. This testing greatly reduces, but does not totally eliminate, the possibility that I may contract one of these illnesses or some other infectious disease from a blood transfusion.

4. I have been informed of alternatives to transfusion, and the most common risks and consequences associated with these alternatives. I understand that if my medical condition permits, I may donate my own blood in advance for transfusion to me if I should need it. I also understand that if time permits, I may designate individuals of my own choice to donate their blood for transfusion to me if I should need it. All of these donations are not completely free of risk and they may not satisfy all of my transfusion requirements.

5. I have been informed of alternatives to transfusion, and the most common risks and consequences associated with these alternatives. I understand that if my medical condition permits, I may donate my own blood in advance for transfusion to me if I should need it. I also understand that if time permits, I may designate individuals of my own choice to donate their blood for transfusion to me if I should need it. All of these donations are not completely free of risk and they may not satisfy all of my transfusion requirements.

6. I understand that if at a later time I decide I do not want to be transfused I may withdraw this consent by notifying my physician or nurse. I also understand that refusal of transfusion may seriously complicate my condition and may be fatal.

7. Missouri law provides that the blood supplied in accordance with this agreement is incidental to the rendition of services and shall not be considered a sale of a product. Therefore, PSDA makes no warranty as to any defects not able to be detected or removed by reasonable use of scientific procedures or techniques.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT. I HAVE HAD THE OPPORTUNITY TO ASK A PHYSICIAN QUESTIONS REGARDING ANY CONCERNS I HAVE ABOUT TRANSFUSION AND I HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION.

____________________________	____________________________
Signature of Patient or person authorized to consent	Date
Relationship to patient	Witness