I understand that the physician believes that a blood transfusion(s) and/or the use of blood products may be needed:

- ☐ During this admission; OR
- ☐ As part of an ongoing course of treatment. I understand that if treatment requires ongoing blood transfusions and/or use of blood products, this consent for blood transfusions and/or use of blood products will remain valid for one year from the date of signature below.

I acknowledge that the physician has explained the risks, benefits and alternatives to transfusion and/or the use of blood products. I understand that the risks associated with transfusion and/or use of blood products include reactions, transmission of disease, and unforeseeable risks including death.

By my signature below, I confirm that:

- ☐ Yes, I authorize the use of blood transfusions and/or use of blood products during this hospitalization or as part of an ongoing course of treatment.
- ☐ No, I request that no blood or blood derivatives be administered to the patient during this hospitalization or course of treatment. I hereby release Stanford Hospital and Clinics, its personnel, the attending physician, and any other person participating in the patient's care from any responsibility whatsoever for unfavorable reactions or any untoward results, which include permanent disability and or death, due to my refusal to permit the use of blood or its derivatives. The possible risks and consequences of such refusal on my part have been fully explained to me by the attending physician and I fully understand that such risks and consequences may occur as a result of my refusal.

________________     ____________   ________________________________________________________
Date Time           SIGNATURE (Patient, Parent or Properly Designated Representative)

________________________________________________________
RELATIONSHIP to Patient

If this document was translated: ________________________________________________________________
SIGNATURE (Interpreter)

________________     ____________   ______________________________
Date Time               Language
☐ Telephone Consent Obtained by Practitioner

2nd Witness to Telephone Consent

Print Name and Title of Witness to Telephone Consent

PHYSICIAN ATTESTATION

I have discussed with the patient or properly designated representative that blood, blood products or blood product transfusion may be used in this hospitalization or during the patient's course of treatment. I have discussed the risks, benefits and alternatives of the transfusion and/or use of blood products.

☐ I have provided the patient/properly designated representative with the pamphlet "A Patient's Guide to Blood Transfusions" concerning the advantages, disadvantages, risks and benefits of autologous blood and/or direct and non-directed homologous blood from volunteers. I have allowed adequate time for the patient to arrange for pre-donation of blood for transfusion purposes except where there is a life threatening emergency, there are medical contraindications or the patient/properly designated representative has waived this right.

☐ The pamphlet "A Patient's Guide to Blood Transfusions" was not given to the patient/properly designated representative and consent was not obtained for the blood transfusion because a life threatening emergency existed, a properly designated representative was not available to provide consent, and the patient/properly designated representative's wishes with respect to blood transfusion were not known prior to the need for blood transfusion.

☐ The patient/properly designated representative refused consent for blood transfusion and/or blood products.

All questions were answered and the patient consents to the procedure.

Date ____________________________ Time ____________________________

Signature and Title of Practitioner _____________________________________________________________________________ Pager Number ____________________________