INFORMED CONSENT FOR TRANSFUSION  
OF BLOOD OR BLOOD PRODUCTS  
OR  
ATTESTATION STATEMENT

Please be aware that this signed consent is valid for the following periods of time.
- Valid for 30 consecutive days for outpatients; and
- Valid for inpatients through the course of their current hospitalization.

1. The doctor has informed me that, in the course of care for myself, my child or the patient that I am authorized to represent, it may be necessary to receive blood or blood products.

2. I understand that transfusions can be done with:
   - Blood donated by others (homologous).
   - My own blood (autologous), if I am the transfusion recipient, under certain non-emergent circumstances.
   - Blood donated by someone I choose (directed) under certain non-emergent circumstances.

3. I understand the risks described to me by the doctor and that risks exist in spite of the fact that blood is screened for hepatitis, AIDS virus, and others. These risks of transfusion are rare.

4. I understand the purpose and benefits of transfusion as they have been described to me by the doctor.

5. I understand the alternatives to blood transfusion, including what could happen if transfusion is refused.

6. I understand that no guarantee has been made and that the transfusion may not be a cure.

7. I have read and fully understand this consent form. I am satisfied with the answers to my questions as explained to me by the doctor.

8. I consent to the transfusion of blood or blood products.

Signature of Patient or Authorized Representative (for informed consent) ____________________ Date/Time ____________________

Physician Signature (for informed consent) ____________________ Date/Time ____________________

Attestation Statement by Physician: I have explained the elements necessary for the patient or authorized representative to make an informed choice and that the transfusion may be refused. The risks associated with refusal have been explained. To the best of my knowledge, all questions have been answered. The patient or authorized representative has been adequately informed and consents to the transfusion of blood or blood products.

Physician Signature (for attestation) ____________________

Date/Time ____________________

Patient Label ____________________

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