Consent Form for the Refusal of Blood Transfusion

Patient Details (or pre-printed label)				
Patient Surname/ family name				
Date Of Birth	Male		Female	
CHI:				

This part to be completed by a Registered Medical Practitioner				
Type Of Operation Investigation or Treatment:				
A patient 'agreement to investigation or treatment consent form' has been completed, if no, please give reason why above	Yes		No	

I acknowledge that this limited consent will not be over-ridden unless revoked or modified, this should be recorded in writing.

I am the	patient		parent		guardian	

I agree (subject to the exclusions below)	• To what is proposed, which has been explained to me by the doctor named on this form • To the use of the type of anaesthetic that I have been told about • To the use of non-blood volume expanders; pharmaceuticals that control haemorrhage and/ or stimulate the production of red cells.	
I have told the doctor **(tick as appropriate)**		That I am one of the Jehovah's Witnesses with firm religious convictions
		I am refusing blood for personal reasons
I understand	That the procedure might not be done by the doctor who has been treating me so far.	
	That my express refusal of allogeneic blood or primary blood components, as indicated on page two, will be regarded as absolute and will NOT be over-ridden in any circumstances by a purported consent of a relative or other person or body. Such refusal will be regarded as remaining in force even though I may be unconscious and/ or affected by medication/ stroke, or other condition rendering me incapable of expressing my wishes and consent to treatment options, and the doctors(s) treating me consider that SUCH REFUSAL MAY BE <u>LIFE THREATENING.</u>	
	That any procedure in addition to the investigation or treatment described on this form, but with the exclusion of the transfusion of allogenic blood or primary blood components, will only be carried out if necessary and in my best interests and can be justified for medical reasons.	
	That details of my treatment, and any consequences resulting, will not be disclosed to any source without my express consent or that of my instructed agent(s) unless required by law.	

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Please indicate your requirements by ticking appropriate boxes -:

	Accept	**Refuse**
Primary Blood Components		
Red Blood cells		
Fresh Frozen Plasma (FFP, plasma)		
Platelets		
White cells (Granulocytes)		

Products containing a minor blood fraction		
Cryoprecipitate		
Albumin		
Intravenous immunoglobulin		
Anti-D immunoglobulin		
Other immunoglobulins e.g. tetanus		

Procedures involving my own blood		
Cell salvage		
Acute normovolaemic haemodilution		
Renal Dialysis		
Plasmapheresis		
Blood radio-labelling		

Recombinant products – not blood sourced		
rFVIIa (Novoseven)		
Erythropoietin		
Others e.g. FVIII		

Other Components/Procedures (please specify)		

Patient		
I confirm that I have indicated above my wishes. I accept or refuse the blood components & procedures as detailed above.		
Signature:	Print name:	Date:
Doctor		
Signature:	Print name:	Date: