Consent for Blood Transfusion

I understand that during my treatment at Northwest Kidney Centers, it may be necessary for me to receive transfusion with blood or blood components (blood products), ordered by my nephrologist (kidney doctor). I understand that use of blood components involve risks. The risks may include reactions, including allergic reactions, fever, hives, serious lung injury, overload of the circulation, increase in potassium levels, production of antibodies that might affect my transplantation and in rare cases infections such as hepatitis, HIV/AIDS. I understand that the blood bank screens blood donors for infection and also tests to match blood for me to lower the medical risks.

I have been informed of treatment choices and risk and benefits have been explained to me, I have been told of all my options including not having transfusions. The results of transfusion have been explained to me and I know the results cannot be guaranteed. My questions have been answered.

This consent for blood and/or blood products is good for the duration of the treatment at NKC.

☐ I give permission to receive blood and/or blood components.

☐ _____ (initial) I refuse permission for blood and/or components.

I understand that I am free to refuse consent to any transfusion at any time.

By signing below, you confirm that you have read the sections above and that you have had 1) each item explained to you; 2) a chance to ask questions; and 3) all of your questions answered.

Name (Print):_____

Signature:_____Date:_____
☐ Patient ☐ Legal Guardian/Representative ☐ Power of Attorney

Witness (Print): _____

Signature: _____ Date:_____

Other: _____

Signature: _____ Date:_____
☐ Translator ☐ Reader

Patient Name:_____ NKC#_____

Health Professional's Statement: I have explained the transfusion procedure including risks, complications, alternative treatment, including no transfusion and anticipated results to the patient and/or his/her representative before the patient or his/her representative consented:

Name and Title (Print): _____

Signature:_____ Date: _____

Patient Name:_____ NKC#_____