

**TO THE PATIENT:** You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (we) voluntarily request Dr. \_\_\_\_\_ as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to **treat** my condition which has been explained to me as:

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and **authorize those procedures:**

**TRANSFUSION OF BLOOD AND BLOOD PRODUCTS.**

I (we) do consent to the transfusion of **blood and blood products** as deemed necessary. I (we) have been given the opportunity to ask questions about alternatives to the use of blood products. If I agree to the use of blood/blood products, I understand that they are not always successful in producing desired results and that there are possible risk such as fever and/or transfusion reaction, which may include kidney failure or anemia, heart failure, hepatitis, A.I.D.S. (Acquired Immune Deficiency Syndrome) and/or other infections. In addition, I am advised that units of blood used for transfusion purposes have been tested by an outside laboratory and have tested negative for venereal disease, hepatitis and for the A.I.D.S. antibody. However, I understand that such blood testing is not one hundred percent (100%) effective. I acknowledge that no guarantees have been made to me about the outcome of the transfusion or the fitness or quality of the blood.

I understand that if I refuse blood or blood derivatives, I hereby release the hospital personnel, and the attending physicians from any responsibility whatever for unfavorable reactions or any untoward results such as organ failure, brain death, liver failure, kidney failure, heart failure, permanent neurological damage and/or death due to my refusal to permit the use of blood or its derivatives.

I (we) understand, it is the policy of Medical Center of Plano not to withhold the administration of blood or blood products to those who need it. Medical Center of Plano reserves the right to seek due process of law in the case(s) of a child, a legally incompetent adult, or a pregnant patient.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the blank spaces have been filled in, and that I (we) understand its contents. I (we) believe that I (we) have sufficient information to give this informed consent and I (we) request the transfusion(s) to be done.

_____ Patient's Signature	_____ Date	_____ Time	_____ Other Legally Responsible Person's Signature	_____ Relationship	_____ Date	_____ Time
_____ Witness Signature/Title/Position	_____ Date	_____ Time	3901 W. 15th St. Plano Texas 75075 _____ Witness Work Address			

I have provided the patient/parent/guardian with information on risks, benefits, and alternatives to treatment and side effects including potential problems related to recuperation as outlined in the above within my area of expertise.

Signature of Physician Obtaining Consent \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



**The Medical Center of Plano**

3901 West 15th Street • Plano, Texas 75075

**Consent for Blood Products**



\*TREAT\*

PATIENT IDENTIFICATION