Holy Cross Hospital
1397 Weimer Rd.
Taos, New Mexico 87571

INFORMED CONSENT: TRANSFUSION OF BLOOD PRODUCTS

I, _____have been advised that due to my medical condition, the chances for my improvement or recovery may be significantly helped by receiving transfusion of blood products such as: packed red blood cells, fresh frozen plasma, platelets or cryoprecipitate. The benefits and risks that are expected from my being transfused have been explained to me. I understand that although the blood products to be administered have been prepared and tested in accordance with strict scientific rules established by the American Association of Blood Banks, there is still a very small (one in a thousand) chance the blood products will be incompatible with my body and a transfusion reaction (Hemolytic Transfusion Reaction) can occur. Although transfusion reactions can be treated successfully, I under-stand that on very rare occasion that can be fatal (one in two hundred fifty thousand transfusions). I understand that allergic reactions to blood products with hives, itching and fever are more common but can be treated and may not even require the transfusion to be stopped. I understand that even with testing by the most up-to-date methods, there is a small chance the blood products may contain a virus that will enter my system and may not be recognized as an infection for many months or years. Even with proper testing, my chances for contracting viral hepatitis may be approximately thirty in every one million transfusions or of contracting HIV in three of one million transfusions. I understand that there are pharmacologic alternatives, such as erythropoietin, colloid solutions or oxygen-carrying solutions including chemically modified hemoglobins or fibrinolytic inhibitors.

I have had an opportunity to ask questions regarding transfusion of blood products for myself or for the patient and with my signature I give consent to administering blood products for myself or for the patient. I agree this Informed Consent may serve for consent to give additional necessary blood products for a time certain to end with this hospitalization or for the complete course of this illness if I have been advised that the future need for transfusion of blood products is quite likely and possibly on a recurrent basis but still related to this same illness.

Witness:_____
Date/Time

_____
Signature of Physician Conducting Informed Consent
Date/Time

_____
Name of Physician Conducting Informed Consent

_____
Patient Name

_____
Patient Signature
Date/Time

_____
Legal Representative
Date/Time

_____
Legal Representative
Date/Time

_____
Relationship to Patient

S10023A (Rev. 1/12)

CONSENT

Holy Cross Hospital
Taos, New Mexico

Informed Consent for Operations/Procedure including Blood And Blood Products

1. I give permission to Dr.(s) _____ to perform the following procedure(s)

   _____

   _____

2. I understand that during the procedure(s), new findings or conditions may appear and require an additional procedure(s) for proper care.
3. My physician has explained the following items:
   - the nature of my condition
   - the nature and purpose of the procedure(s) that I am now authorizing
   - the possible complications and side effects that may result, problems that may be experienced during recuperation and the likelihood of success
   - the benefits to be reasonably expected from the procedure(s)
   - the likely result of no treatment
   - the available alternatives, including the risks and benefits
   - the other possible risks that accompany any surgical and diagnostic procedure (in addition to those already discussed). I acknowledge that neither my physician nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the procedure(s) that I am now authorizing.
   - that other associate(s)_____ may help my physician, or perform certain aspects of the described procedure(s) such as:

     _____
4. Any tissue or specimens taken from my body as a result of the procedure(s) may be examined and disposed of, retained, preserved, or used for medical, scientific or teaching purposes by the hospital.
5. I understand that my procedure(s) may be photographed or videotaped for the purpose of advancing medical care and education, provided my identity is not revealed by the pictures or by the descriptive text accompanying them, I also understand that observers may be present in the room.
6. I understand that during or after the procedure(s) my physician may find it necessary to give me a transfusion of blood or blood products. My physician has explained the alternatives to, and possible risks of transfusion.
7. I understand what my physician has explained to me and have had all my questions fully answered.

After talking with my physician and reading this form, I give my consent to the procedure(s) described above.

Signature of patient or
Legal Representative: _____ Date: _____ Time: _____

If Legal Representative, relationship to patient:_____

Witness: _____

Verbal or Telephone Consent: Patient cannot consent because:_____
Name of Legal Representative: _____Date: _____ Time:_____

Witness: _____ Witness:_____

I have explained the risks, benefits, potential complications, and alternatives of the treatment to the patient and have answered all questions to the patient's satisfaction, and he/she has granted consent to proceed.

Physician signature:_____ Date:_____Time:_____

S10013E (rev. 6/05)