

I consent that any tissues, specimens, organs or limbs removed from my body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

I consent to the presence of any medically oriented personnel designated by the physician including students and business personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in such procedure(s).

I consent to allow all licensing, accrediting and/or regulatory agencies access to my medical records.

**BLOOD TRANSFUSION CONSENT**

I understand that in the event of severe blood loss I may require a blood transfusion. I also understand that there are risks associated with blood transfusion including, but not limited to, HIV (AIDS) infection, hepatitis, and other infections as well as fever, chills, allergic reactions, accumulation of fluid in the lungs and break down of red blood cells (hemolysis). I understand that there are risks associated with alternatives to blood transfusion, for example, self donation, directed donors, intraoperative hemodilution. I further understand that in certain life threatening emergency situations, it may be necessary to administer blood and/or blood products before all laboratory tests have been completed. I have been advised that I may provide my own donors or pre-deposit my own blood if I am medically able to do so and if my transfusion is not an emergency. I understand that there are no practical alternatives to the use of blood and that the failure to transfuse when needed could potentially cause additional medical problems or complicate existing ones or lead to serious illness or death. The use of blood and/or blood products has been explained to me and I have been given an opportunity to ask questions. I hereby consent to receive blood and/or blood product transfusion(s).

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person authorized to sign \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Witness to Signature \_\_\_\_\_

**I have been informed of the above and hereby refuse blood and/or blood product transfusion.**

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person authorized to sign \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Witness to Signature \_\_\_\_\_

**I understand and acknowledge that by signing this form I have read or had read this form or had it explained to me and that I fully understand its contents including without limitation:**

- a. A diagnosis of the condition requiring the procedure
- b. The nature and purpose of the procedure(s)
- c. The material risks of the procedure
- d. The likelihood of success of the procedure(s)
- e. The practical alternatives to the procedure(s)

**and that such information was provided through the use of video tapes, audio, pamphlets, booklets or other means of communication and through direct conversation with the responsible physician or other health care providers under the supervision and control of the responsible physician, and that I have been given ample opportunity to ask questions and that any and all questions have been answered to my satisfaction.**

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Relationship if not Patient \_\_\_\_\_

Patient unable to sign because: \_\_\_\_\_

Witness to Signature \_\_\_\_\_

This consent may have other consents included as referenced.

Name/signature of Physician or Medical Professional explaining the procedure to the patient or guardian:

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