

JEHOVAHS WITNESS BLOOD PRODUCT AND TECHNIQUE CONSENT / DECLINE CHECKLIST

My signature below indicates that I request no blood derivatives other than the ones which I have designated in this consent be administered to me during this hospitalization. My attending physician, _____ M.D. has reviewed and fully explained to me, ***the risks and benefits***, of the following blood products and methods for alternative non-blood medical management and blood conservation available to me. My attending physician _____ M.D. has also **fully explained to me the potential risks associated by not authorizing blood and / or non blood management during this hospitalization.**

	ACCEPT	DO NOT ACCEPT
COMPONENTS OF HUMAN BLOOD		
Red Blood Cells	_____	_____
Fresh Frozen Plasma	_____	_____
Platelets	_____	_____
Cryoprecipitate	_____	_____
Albumin	_____	_____
Plasma Protein Fraction	_____	_____

INTRAVENOUS FLUIDS WHICH ARE NOT COMPONENTS OF HUMAN BLOOD		
Hetastarch	_____	_____
Balanced Salt Solutions	_____	_____

MEDICATIONS WHICH CONTAIN A FRACTION OF HUMAN BLOOD		
Rhogam	_____	_____
Erythropoietin	_____	_____
Human Immunoglobulin	_____	_____
Tisseel	_____	_____

TECHNIQUES FOR BLOOD CONSERVATION / PROCESSING		
Hemodilution	_____	_____
Cell Saver	_____	_____
Autologous Banked Blood	_____	_____
Cardiopulmonary Bypass	_____	_____
Chest Drainage Autotransfusion	_____	_____
Plasmapheresis	_____	_____
Hemodialysis	_____	_____
Other _____	_____	_____

PLEASE CIRCLE WHICH ONE APPLIES

I do (do not) have a durable power of attorney.

I accept (do not accept) this consent as an addendum to my durable power of attorney.

I fully understand the options available to me and hereby release the hospital, its personnel, the attending physician and any other person participating in my care from any responsibility whatsoever for unfavorable reactions or any untoward results due to my decision not to permit the use of blood or its derivatives. The possible risks and consequences of such refusal on my part have been fully explained to me by my attending physician. I fully understand such risks and consequences may occur as a result of my decision.

DATE: _____ **TIME:** _____

SIGNATURE: _____
(patient/parent/guardian/conservator)

RELATIONSHIP: _____

WITNESS: _____