



**PATIENT  
INFORMED  
CONSENT**

- Legacy Emanuel Hospital
- Legacy Good Samaritan Hospital
- Legacy Meridian Park Hospital
- Legacy Mount Hood Medical Center
- Legacy Salmon Creek Hospital
- \_\_\_\_\_

Full Name of Patient:

\_\_\_\_\_  
*(Place patient identification label in this box)*

**Name of Procedure(s): Transfusion of Blood or Blood Product (s)**

I understand that the **risks** of transfusion are low, and include but are not limited to: infection (HIV, hepatitis, other viruses), antibody development and immune reactions, contamination by bacteria, difficulty breathing related to antibodies in the donor blood, temporary reduction in my natural immunity\*.

I understand that there are **alternatives to transfusion** that include administration of hormones that stimulate the bone marrow (takes weeks to be effective), mineral supplementation (takes weeks to months to be effective), collection of my own blood during surgery (for certain surgical patients only).

I understand that the **benefits** of blood transfusion include improved oxygen delivery to vital organs (red blood cell transfusions), improved blood clotting (plasma, platelets, cryoprecipitate).

The procedure(s), risks and alternatives listed above were explained to me. I had the opportunity to ask questions and all of my questions about the procedure(s), risks and alternatives were answered to my satisfaction. I understand I have the right to accept or refuse transfusion of blood or blood products.

\* Please see brochure "Blood Transfusion Information for Patients", current edition, for more information about transfusions, including statistics on infectious disease risks.

**I Consent to the Transfusion of Blood or Blood Products:**

\_\_\_\_\_  
(Patient's Signature\*\*) (Printed Name) (Date and Time)

\*\*Patient is unable to consent because: \_\_\_\_\_. I therefore consent for patient:

\_\_\_\_\_  
(Authorized Consenter's Signature) (Printed Name)

\_\_\_\_\_  
(Witness' Signature)  Mark this box if telephone consent

**I Have Explained the Above Procedure(s) to the Patient or Authorized Consenter:**

\_\_\_\_\_  
(Physician's/Credentialed Provider's Signature) (Printed Name)

Place original form in chart. For procedures performed in Washington, provide a signed copy to the patient.

Whenever possible, the patient should complete the consent process. In the event the patient is unable to consent due to age or a physical or mental condition, the consent form must be signed by a person the law recognizes as someone who may act for the patient.

**The Following Individuals May Sign the Consent Form:**

Adult patients: Patients 18 years or older who are not suffering from a physical or mental condition that prohibits them from understanding what they are doing.

Minor patients: In Oregon, patients under 18 years of age if they are: (a) married, (b) emancipated by court order or (c) 15 years of age or older and seeking hospital care, or diagnosis or treatment by a physician or dentist licensed by the State of Oregon. ORS §109.640. The physician or practitioner and the hospital are permitted to notify the parent or guardian regarding the treatment without the consent of the minor. ORS §109.650.

In Washington, patients under 18 years of age if they are (a) married to a person age 18 or older or (b) emancipated by court order.

**Blood Transfusion Consents:**

Outpatient – valid for one year.

Inpatient – valid for duration of inpatient visit. Must be resigned with each hospital admission.