INFORMED CONSENT FOR BLOOD / BLOOD PRODUCTS

I, ___________________________________________________________ have been advised by
(Name of Patient, Relative or Legal Guardian)

Dr. ______________________________________ (and/or such associates selected by him/her) that I
may need a blood transfusion and/or blood products.

I have been informed that the blood and/or blood products used by Saint Francis Hospital are from
the Connecticut Red Cross volunteer donors.

I have been informed to my satisfaction and I understand the benefits and potential risks of receiving
blood transfusion. I understand that the potential risks may occur as a result of a blood transfusion
include:

Occasional Complications: Fever and allergic reactions
Infrequent Complications: Transmission of such infectious diseases as hepatitis
Very Rare Complications: Hemolysis (destruction of transfused red blood cells),
transmission of HIV/AIDS and severe transfusion reactions
including shock.

I understand that while the precautions generally taken in testing and screening of the donor
significantly reduce these complications, blood and blood products can never be 100% safe.

I have been informed about the reasonable alternatives to receiving a blood transfusion and the
common benefits and risks of these alternatives. I have been advised of the consequences if I refuse
a blood transfusion.

I have been informed that if I do not understand any of the information that has been provided to me
regarding blood transfusion, if I have any special concerns or want more detailed information, I may
ask more questions and get more information before signing this consent agreeing to treatment.

_________________________________________________________  _____ / _____ / _____  _________________
Signature of Patient, Relative or Authorized Agent for Patient          Date                   Time

_________________________________________________________  _____ / _____ / _____
Signature of Physician  ____________________________  Date                   Time