CLEVELAND CLINIC

Blood Products Refusal Consent

IMPRINT SIZE
3 ½" X 1 ¾"

Who may use this form to refuse to receive blood products or minor blood fractions?

- *An adult patient (18 years or older)*
- *An authorized representative on behalf of a minor patient* or a patient lacking decision-making capacity*
- *Minors declared emancipated or mature minors within the meaning of the Cleveland Clinic Informed Consent Policy*

**This form may NOT be used for parents to refuse blood products or fractions for their minor children if such refusal may reasonably lead to the death or disability of the child.*

A consent form to receive blood products or fractions signed after this form makes this refusal form invalid.

I, the patient below (or authorized representative), declare that I refuse blood products and/or fractions regardless of my medical condition and the consequences, even if my licensed health care provider tells me that the blood products or fractions will save my life or preserve my health.

My **initials** below indicate my decision for each blood product or fraction:

Blood Product	Accept	Refuse	Minor Blood Fractions	Accept	Refuse
Red Blood Cells			Albumin		
Plasma			Erythropoietin (may contain Albumin)		
Platelets			Medications containing Albumin		
Cryoprecipitate (Fraction of plasma clotting factors)			Immune Globulins (includes Rh immunoglobulin)		
Other:			Human Prothrombin Complex		
			Other:		

My refusal applies to:

☐ My present procedure or treatment: (name of procedure or treatment)_____

OR

☐ My entire present admission: (admission date)_____

I have discussed my decisions above and their related risks with my licensed health care provider, who has answered all my questions. In addition, I understand and agree that:

- My refusal of blood products and/or fractions could cause death or disability.
- I can change my mind at any time, and accept some or all blood products or fractions. If I do so, this blood refusal consent form will become invalid; if applicable, a new blood transfusion consent and/or blood refusal consent form will need to be signed.

_____ _____ _____

Signature of Patient or Patient's Authorized Representative | Date | Time

_____

Printed Name Patient and Patient's Authorized Representative (if applicable)

_____ _____ _____

Signature of Physician or Licensed Independent Practitioner | Date | Time

_____

Printed Name of Physician or Licensed Independent Practitioner