Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke
Québec

INSTALLATION : _____

CONSENT

TRANSFUSION THERAPIES AND BLOOD COMPONENTS IN PATIENTS REFUSING SOME OR ALL BLOOD PRODUCTS

DATE | Year | Month | Day |

☐ I hereby give consent, for myself or for the patient identified below, for the transfusion and/or the administration of the following products:

LABILE BLOOD PRODUCTS		
Red blood cells	☐ Yes	☐ No
Platelets	☐ Yes	☐ No
Plasma	☐ Yes	☐ No
Comments : _____		

BLOOD COMPONENTS DERIVED FROM HUMANS		
Cryoprecipitate	☐ Yes	☐ No
Albumin	☐ Yes	☐ No
Human coagulation factors (Ex. : fibrinogen, factor VIII, factor IX, von Willebrand factor and others)	☐ Yes	☐ No
Prothrombin complex concentrate (Ex. : Beriplex)	☐ Yes	☐ No
Antithrombin and protein C concentrates	☐ Yes	☐ No
Hemostatic matrices (Ex. : Floseal)	☐ Yes	☐ No
Fibrin sealants (Ex. : Tisseel, Artiss, Evicel)	☐ Yes	☐ No
Immunoglobulins	☐ Yes	☐ No
Comments : _____		

RECOMBINANT PRODUCTS NOT DERIVED FROM BLOOD		
Recombinant activated factor VII (Ex. : Niastase)	☐ Yes	☐ No
Recombinant coagulation factors (Ex. : factor VIII, factor IX)	☐ Yes	☐ No
Bovine gelatin (Ex : Gelfoam)	☐ Yes	☐ No
Oxidized cellulose (Ex : Surgicel, Oxycel)	☐ Yes	☐ No
Erythropoiesis stimulating agents (Ex. : erythropoietin/darbepoietin)	☐ Yes	☐ No
Comments : _____		

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PATIENT BLOOD MANAGEMENT TECHNIQUES		
Hemodilution	☐ Yes	☐ No
Autotransfusion (« cellsaver »)	☐ Yes	☐ No
Absolute need for a closed circuit always connected to the patient	☐ Yes	☐ No
Comments : _____		

I confirm receiving verbal information on the nature of the treatment, its expected benefits, potential risks, alternatives, and the possible consequences of refusing treatment. I understand that I or my legal representative may revoke consent at any time. This consent is valid for the duration of the current care episode.

Signature of the patient or legal representative	Name in block letters	Date

MEDICAL CONFIRMATION

I confirm that I have explained the nature of the treatment, its expected benefits, risks, alternatives, and the consequences of refusing treatment to the patient or their legal representative and have answered all their questions.

Physician's signature	Name in block letters	Permit number	Date