SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

❑ RUH ❑ SCH ❑ SPH Other _____

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

INFORMED CONSENT FOR ADMINISTRATION OF BLOOD COMPONENTS AND/OR PLASMA PROTEIN PRODUCTS

Patient Name: _____ Date: _____
(Please Print)

1. My most responsible healthcare practitioner [MRHP] (_____) has informed me that, in the course of my treatment, I may require a transfusion of blood components and/or plasma protein products.
2. I understand blood components are collected from blood donated by volunteer donors. I understand that Canadian Blood Services is responsible for selecting blood donors, collecting, testing for transmissible diseases, and storing blood. I also understand Saskatoon Regional Health Authority and its Transfusion Medicine Laboratory are responsible for proper blood storage, testing, and preparation for transfusion.
3. I understand plasma protein products are manufactured by pharmaceutical companies that are accountable for their products, including adherence with Health Canada Standards.
4. I have been informed of and understand the benefits associated with blood transfusion and/or plasma protein products.
5. I acknowledge any product obtained from human sources may contain unknown agents that transmit disease. My MRHP and I have discussed the risks associated with disease transmission through transfused blood components and/or plasma protein products.
6. My MRHP also informed me of the possibility I might have a reaction to the transfusion. The symptoms and measures used to reduce the risk of reactions were explained but I am aware not all measures can eliminate or prevent all reactions.
7. The risks of receiving or not receiving blood products and/or plasma protein products have been discussed with me.
8. My MRHP and I have discussed alternative treatments to the transfusion of blood components and/or plasma protein products, as they relate to my medical condition.
    i. I have been given information about the component or product I will be receiving, which may include the *SHR information for Patients about Blood Transfusion and Tissue Transplantation* booklet. I have been given the opportunity to review it and ask any questions I might have for my MRHP. My questions and concerns have been discussed and answered to my satisfaction.
9. I understand I have the right to change my mind at any time, including after I have signed this form following a discussion with my MRHP.

_____ _____
(Signature of Patient or Substitute Decision Maker) (Date and Time)

Autologous blood use (applicable to donors with Transfusion Medicine Director approval only).
I have donated my own blood for transfusion, and I understand this is the product I shall receive. I have been made aware of the risks of donating or receiving my own blood.

_____ _____
(Signature of Patient or Substitute Decision Maker) (Date and Time)

Physician Statement and Signature:

I acknowledge I have explained to the patient all the points under *SHR Consent for Blood Components and Plasma Protein Products (7311-50-004)*. It is my opinion the patient/substitute decision maker understood the decision.

_____ _____
(Signature of Most Responsible Health Practitioner) (Date and Time)

INFORMED CONSENT FOR ADMINISTRATION OF BLOOD COMPONENTS AND/OR PLASMA PROTEIN PRODUCTS

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

For use in Emergent/Life-threatening Circumstance ONLY:

A. For use in emergency situations where capacity cannot be determined and informed consent cannot be obtained

A. I certify the delay in administering this transfusion will seriously endanger the health or life of the patient, and to the best of my knowledge, the patient has no objection to receiving blood.

_____ _____
(Most Responsible Health Practitioner) (Date and Time)

_____ _____
(Consulting Physician) (Date and Time)

B. For use when a patient does not show capacity for consenting

B. I certify this patient, who does not show capacity for consent, is in need of a transfusion. To my knowledge this patient has not previously withheld consent to transfusion. The transfusion is necessary for the benefit of the patient. To my knowledge this patient does not have a substitute decision maker.

_____ _____
(Most Responsible Health Practitioner) (Date and Time)

Certification by Interpreter:

I, _____, have given the translation in _____.
(Please print your name) (State the patient's language here)

I hereby certify I was present and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision maker by the MRHP _____, who explained the Consent for Administration of Blood Components and/or Plasma Protein Products to the patient as noted above.

_____ _____
(Signature of Interpreter) (Date and Time)

Treatment for Non-Canadian Residents:

The patient acknowledges that treatment including blood transfusion was performed in the Province of Saskatchewan, and the Courts of the Province of Saskatchewan shall have jurisdiction to entertain any complaint, demand, claim, or cause of action, whether based on alleged breach of contract or alleged negligence arising from the treatment or service. The patient hereby agrees he/she will commence any such legal proceedings in the Province of Saskatchewan and only in the Province of Saskatchewan and hereby submits to the jurisdiction of the Courts in the Province of Saskatchewan.

_____ _____
(Signature of Patient of Substitute Decision Maker) (Date and Time)