

Blood Products Refusal Form**IMPRINT SIZE****3 ½" X 1 ¾"**

*This form should be used for adult patients (18 years old or older), or minors who have been declared emancipated or who are mature minors within the meaning of the Cleveland Clinic Informed Consent Policy. *This form may NOT be used to enable parents to refuse blood or blood products for their minor children. A consent form to receive blood products signed after the execution of this form would supersede this form.*

I, the patient whose name appears below (or legal representative), have signed this form to declare my decision that I refuse to have blood or blood products administered to me. I have discussed my decision, including the risks of my decision, with my physician, who has answered all my questions regarding my decision. I have checked below all boxes that apply to my decision to refuse blood or blood products. My refusal applies to, and only to, the procedure or treatment described below:

NAME OF PROCEDURE OR TREATMENT:**REFUSAL OF BLOOD**

I **refuse** **allogeneic blood** (another person's blood) under any and all circumstances, regardless of my medical condition and regardless of the consequences, even if my physician and other health care providers tell me that only blood transfusion therapy will preserve my life or health.

☐ I REFUSE ALL *whole blood: I want no red cells, no white cells, no platelets, and no blood plasma*

USE OF MINOR BLOOD FRACTIONS

Minor blood fractions are substances that come from human blood such as albumin, clotting factors, cryoprecipitate, immunoglobulin as well as others. These products may be beneficial for certain health conditions.

- ☐ I REFUSE ALL minor blood fractions
- ☐ I ACCEPT ALL minor blood fractions
- ☐ I ACCEPT ONLY the minor blood fractions checked below
 - ☐ Albumin
 - ☐ Clotting Factors
 - ☐ Cryoprecipitate
 - ☐ Immunoglobulin

I understand that death or disability may result from my refusal to accept blood or blood products. I understand that I may reverse my decision and accept blood or blood products at any time. I understand that this form becomes void if I consent to receiving blood or minor blood fractions, as applicable, in the future.

Signature of Patient or Patient's Legal Representative

Date

Time

Printed Name of Patient (and legal representative, if any*)

Witness – Cleveland Clinic Employee

Printed Name of Witness

