Community Health Network
San Francisco General Hospital
Medical Center

PT NAME

DOB

MRN

PATIENT ID/ADDRESSOGRAPH

REFUSAL TO PERMIT BLOOD TRANSFUSION

Physician: Please contact Risk Management (phone 206-6600 or 206-6052) as soon as possible if there is an issue whether transfusion should be administered or should be withheld, or if withholding transfusion could endanger the patient's life or health.

I request that no blood or blood component be administered to _____ (Print name of patient) _____ during this hospitalization / treatment period.

I hereby release the hospital, its personnel, the physician(s) and any other person(s) participating in my care from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its components.

The possible risks and consequences of such refusal on my part have been fully explained to me by my physician, Dr. _____, and I fully understand that such risks and consequences may occur as a result of my refusal.

Date: _____ Time: _____ AM/PM

Signature: _____ Relationship: _____ (self / parent / conservator / guardian)

Witness: _____ (Signature) / _____ (Print name)

Interpreter: _____ (Signature) / _____ (Print name)

Physician: _____ (Signature) / _____ (Print name)

REFUSAL TO PERMIT BLOOD TRANSFUSION

ORIGINAL - MEDICAL RECORD COPY

FILE IN ADVANCE DIRECTIVE SECTION OF RECORD