

San Francisco
Health Network
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER

NAME

DOB

MRN

PCP

CONSENT TO TRANSFUSION

Patient ID / Addressograph

EMERGENCY TRANSFUSION

Consent could not be obtained without delaying transfusion which would be harmful to patient.

Provider: (mm/dd/yy) / (hh:mm) _____ / _____ / _____
Date Time Print Name Signature CHN ID#

II. PATIENT DISCLOSURE (Applies only to medical or surgical procedures that may reasonably result in a need for transfusion) This section does not apply when there are medical contraindications to pre-donation or when a life-threatening emergency exists.

Documentation of compliance with Health and Safety Code § 1645 (Paul Gann Blood Safety Act)

The above named patient can be expected to need transfusion as the result of a medical or surgical procedure. **As the patient's provider, I attest to the following:**

- I have discussed with the patient, or patient's representative, advantages and disadvantages of autologous and designated blood donation options, as well as medical contraindications and restrictions to autologous transfusion.
- The patient, or patient's representative, has been provided with a copy of the California Department of Health Services brochure, "A Patient's Guide to Blood Transfusion."
- I have allowed adequate time for the patient or other person(s) to pre donate blood (minimally 72 hours from blood center notification) OR the patient has declined or waived this time allowance.

Provider: (mm/dd/yy) / (hh:mm) _____ / _____ / _____
Date Time Print Name Signature CHN ID#

SIGN ONLY IF ALL LISTED CONDITIONS HAVE BEEN MET