

Medical Record Number

Patient Name



**CONSENT • BLOOD TRANSFUSIONS, BLOOD  
PRODUCTS AND GANN ACT**

Addressograph or Label - Patient Name, Medical Record Number

I understand that the physician believes that a blood transfusion(s) and/or the use of blood products may be needed:

- During this admission; OR
- As part of an ongoing course of treatment. I understand that if treatment requires ongoing blood transfusions and/or use of blood products, this consent for blood transfusions and/or use of blood products will remain valid for one year from the date of signature below.

I acknowledge that the physician has explained the risks, benefits and alternatives to transfusion and/or the use of blood products. I understand that the risks associated with transfusion and/or use of blood products include reactions, transmission of disease, and unforeseeable risks including death.

By my signature below, I confirm that:

- Yes, I authorize the use of blood transfusions and/or use of blood products during this hospitalization or as part of an ongoing course of treatment.
- No, I request that no blood or blood derivatives be administered to the patient during this hospitalization or course of treatment. I hereby release Stanford Hospital and Clinics, its personnel, the attending physician, and any other person participating in the patient's care from any responsibility whatsoever for unfavorable reactions or any untoward results, which include permanent disability and or death, due to my refusal to permit the use of blood or its derivatives. The possible risks and consequences of such refusal on my part have been fully explained to me by the attending physician and I fully understand that such risks and consequences may occur as a result of my refusal.

Date	Time	SIGNATURE (Patient, Parent or Properly Designated Representative)
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RELATIONSHIP to Patient

If this document was translated: \_\_\_\_\_  
SIGNATURE (Interpreter)

Date	Time	Language
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2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4



