MARKHAM STOUFFVILLE HOSPITAL CORPORATION

381 Church Street,
P.O. Box 1800
Markham, Ontario L3P 7P3

☐ Markham Site ☐ Uxbridge Site

CONSENT FOR TRANSFUSION OF BLOOD AND/OR BLOOD PRODUCTS

1. I have been informed that during my treatment, it may be necessary to receive a transfusion of blood and/or blood products. I understand what a transfusion is and the procedure that will be used.
2. I have been given written educational material about the risks and benefits of blood products and have had the opportunity to discuss any questions and concerns with my health care provider.
3. I understand that the Canadian Blood Services (CBS) has taken the accepted precautions in selecting blood donors and in collecting, testing and storing blood and blood products for transfusion. I understand that Markham Stouffville Hospital and its staff have taken the accepted precautions in storing and preparing the product(s) for transfusion.
4. I have been told about the risks of receiving a transfusion from volunteer donors. I understand that no absolute guarantees can be or have been given to me concerning the potential risks associated with the transfusion of blood and/or blood products. I understand that risks exist even though the bood has been tested and may even be my own.
5. In some cases, my own blood (autologous) may be used for transfusion. I have been made aware that there are risks even with donating or receiving my own blood and I have discussed this with my doctor. I have been told that even if my own blood is used, it may be necessary to give me additional blood or blood products donated by others.

The treatment and transfusion procedure has been fully explained to me. By signing below I accept that I understand the associated risks and benefits and that I have had an opportunity to ask and have my questions answered.

_____	**OR**	_____
Signature of Patient		Signature of Substitute Decision Maker
_____		_____
PRINT Patient Name		PRINT Substitute Decision Maker Name/Relationship
_____		_____
Date		Date

Physician Statement:

I have explained the nature of the treatment, its associated risks, benefits, possible alternatives, as well as the likely consequences of not having treatment. I have provided the appropriate written information and have answered any request for additional information by the patient or Substitute Decision Maker.

Physician/Surgeon Signature _____ Date _____

PRINT Physician/Surgeon Name _____