

Facility: **Elmhurst Hospital Center**

Chart No.

Name

Unit

(Patient Imprint Card)

**INFORMED CONSENT
PROGRESS NOTE**

(The Informed Consent Form HHC 100 B-3 on the reverse side must also be completed)

I explained the risks, benefits, side effects and alternatives of the proposed transfusion of blood and blood products to the above named patient for treatment of _____ (Identify Diagnosis).

As I explained to the patient, the risks, benefits, side effects, alternatives, intended goals and likelihood of success of the transfusion to achieving healthcare goals (including potential problems with recuperation) include but are not limited to:

Risks and side effects of the proposed care: -Allergic/Anaphylactic Reactions - Fever
-Acute or Delayed Hemolytic Reaction which may lead to shock -Respiratory Distress/Lung Injury
-Infection, which may include exposure to bacteria, parasites or viruses like HIV/Hepatitis C (all very rare)

Benefits: -Correction of anemia, and improved symptoms as a result (decreased fatigue/chest pain/shortness of breath)
-Improved ability to form blood clots in order to minimize risk of abnormal bleeding

Alternatives (including risks, side effects and benefits thereof): - None

Risks of not receiving this blood and blood product: -Worsening anemia, and worsening chest pain, shortness of breath or fatigue
-Continued hemorrhage -Decreased ability to form blood clots

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider* _____ **Date** _____ **and** _____ **Time** _____ **am**
 _____ **pm**

Print Name and Identification Number

IF SOMEONE IS MAKING HEALTH CARE DECISIONS FOR THE PATIENT, THE ATTENDING PHYSICIAN MUST CERTIFY THAT THE PATIENT LACKS DECISIONAL CAPACITY.

ATTENDING PHYSICIAN'S CERTIFICATION

I have examined the above-named patient and it is my professional medical opinion that this patient lacks decisional capacity to make informed health care decisions. I understand that if this patient has appointed a health care agent to make these decisions, a copy of the patient's Health Care Proxy must be inserted in the medical record. If the patient's surrogate has consented to the proposed treatment for the patient, the surrogate has signed the consent form.

Signature of the Attending Physician _____ **Date** _____ **and** _____ **Time** _____ **am**
 _____ **pm**

Print Name and Identification Number

* Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent. See also HHC Consent Policy, Article III.