Facility: **Elmhurst Hospital Center**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Chart No.

Name

Unit

(Patient Imprint Card)

CONSENTIMIENTO INFORMADO PARA LA TRANSFUSIÓN DE SANGRE Y HEMODERIVADOS
(INFORMED CONSENT FOR TRANSFUSION OF BLOOD AND BLOOD PRODUCTS)

FORM B-3

Para uso de los pacientes que reciben transfusiones como tratamiento médico, que no es parte de un procedimiento diagnóstico, médico o quirúrgico invasivo. / To be used for patients receiving transfusion(s) as their medical treatment, which is not part of an invasive diagnostic, medical or surgical procedure.

He sido informado por _____ (Nombre del médico tratante o proveedor de atención médica autorizado / **Name of Attending Physician or Authorized Health Care Provider**) sobre los riesgos, beneficios y alternativas disponibles a la transfusión de sangre y hemoderivados.

Se me ha explicado que aunque la ley dispone que toda la sangre y hemoderivados utilizados para transfusiones deben ser analizados para detectar la presencia de agentes infecciosos potencialmente contagiosos, incluyendo los organismos que causan SIDA, hepatitis y sífilis, no es posible eliminar completamente la potencial transmisión de todas las enfermedades, si bien el riesgo para mí es mínimo.

También entiendo que en raras ocasiones se producen reacciones a las transfusiones que pueden provocar dificultades para respirar, fiebre, dolor, escalofríos, náuseas, ictericia, daño renal, trastornos de coagulación, anemia, insuficiencia cardíaca e incluso la muerte.

Se me ha dado la oportunidad de hacer preguntas sobre mi afección y sobre la necesidad de recibir transfusiones, incluyendo las terapias alternativas y creo que he recibido suficiente información para tomar esta decisión informada y doy mi consentimiento para la administración de sangre y hemoderivados.

Firma del paciente o del padre, madre o tutor legal del paciente menor de edad (Signature of Patient or Parent/Legal Guardian of Minor Patient)	**Fecha (Date)**	**(and)**	**Hora (Time)**	**y**	**am pm**

If the patient cannot consent for him/herself, the signature of either the health care agent or legal guardian who is acting on behalf of the patient, or the patient's surrogate who is consenting to the treatment for the patient, must be obtained.

Firma del agente de salud o tutor legal (Signature of Health Care Agent/Legal Guardian) (Place a copy of the authorizing document in the medical record)	**Fecha (Date)**	**(and)**	**Hora (Time)**	**y**	**am pm**
Firma y vínculo con el representante (Signature and Relation of Surrogate)	**Fecha (Date)**	**(and)**	**Hora (Time)**	**y**	**am pm**

TESTIGO (WITNESS):

I, _____ am a staff member who is not the patient's physician or authorized health care provider and I have witnessed the patient or other appropriate person voluntarily sign this form.

Firma y cargo del testigo (Signature and Title of Witness)	**Fecha (Date)**	**(and)**	**Hora (Time)**	**y**	**am pm**

INTÉRPRETE/TRADUCTOR (INTERPRETER/TRANSLATOR): (To be signed by the interpreter/translator if the patient required such assistance.)

To the best of my knowledge the patient understood what was interpreted/translated and voluntarily signed this form.

Firma del intérprete/traductor (Signature of Interpreter/Translator)	**Fecha (Date)**	**(and)**	**Hora (Time)**	**y**	**am pm**

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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.

_____ _____ and _____ am

Signature of Attending Physician or Authorized Health Care Provider* **Date** **Time** 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.

_____ _____ and _____ am

Signature of the Attending Physician **Date** **Time** 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.