BLOODLESS PROGRAM ENROLLMENT

1. ADVANCE DIRECTIVE

_____ Initials — I have documented my **refusal of blood transfusion** in a Durable Power of Attorney for Health Care or advance directive, and have provided a copy for my medical record.

_____ Initials — I direct **no blood transfusion** be given to me even if health care providers believe only blood transfusion will extend or preserve my life. I refuse to store my own blood for later infusion*.

NO TRANSFUSION OF:

- **WHOLE BLOOD**
- **RED BLOOD CELLS**
- **WHITE BLOOD CELLS**
- **PLATELETS**
- **PLASMA (INCLUDING FFP)**
- **CRYOPRECIPITATE IN PLASMA**

* Patients who will accept at least one component listed above, will pre-donate their own blood, or accept directed donation do not qualify for Bloodless Program enrollment. See Transfusion Restrictive protocol.

2. SPECIFIC REQUIREMENTS (BLOOD FRACTIONS AND PROCEDURES INVOLVING MY OWN BLOOD)

A. Minor fractions from blood (e.g. albumin, clotting factors, immunoglobulin, etc.)

_____ Initials	I ***accept*** minor blood fractions used in medicine or as medicine_____ _____ _____ _____ Lines provided for additional instructions, if any	_____ Initials	I ***refuse*** all minor blood fractions used in medicine or as medicine.

B. Procedures that return my own blood to me (e.g. dialysis, cell salvage, epidural blood patch, etc.)

_____ Initials	I ***accept*** procedures that return my own blood to me _____ _____ _____ _____ _____ Lines provided for additional instructions, if any	_____ Initials	I ***refuse*** any procedures where my own blood is returned to me.

Washington State law gives me the right and responsibility to make decisions about my health care. I understand refusing blood transfusion may harm my health or could hasten my death. I have had the opportunity for my questions to be answered by SMC staff. I have read this document, fully understand its contents, and voluntarily sign it.

My Bloodless Program enrollment instructions will be reviewed with me at each hospital encounter at SMC. I may change my instructions or opt out of the Bloodless Program by notifying SMC staff at any time.

Patient Signature (or legal representative) _____ Date _____ Time _____

Print Name (and legal relationship if other than patient) _____

Witness _____ Date _____ Time _____
(Witness to Signature Only)

PATIENT LABEL

SWEDISH
SEATTLE, WASHINGTON

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