1. **Advance Directive**

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.

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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*.

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**NO TRANSFUSION OF:**

- Whole Blood
- Red Blood Cells
- White Blood Cells
- Platelets
- Plasma (including FFP)

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* 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.)

<table>
<thead>
<tr>
<th>Accept</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>I accept minor blood fractions used in medicine or as medicine.</td>
<td>I refuse all minor blood fractions used in medicine or as medicine.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Accept</th>
<th>Refuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>I accept procedures that return my own blood to me.</td>
<td>I refuse any procedures where my own blood is returned to me.</td>
</tr>
</tbody>
</table>

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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 (or legal relationship if other than patient) __________________________

Witness __________________________________________ Date ___________ Time _________

(Witness to Signature Only)