REFUSAL OF BLOOD PRODUCTS

1. Blood Products. Initial each blood product you absolutely **REFUSE**.
Note: Products you DO NOT initial (left blank) may be used in an emergency.

A. _____ Whole Blood (Initials) B. _____ Platelets (Initials) C. _____ White cells (granulocytes) (Initials)
D. _____ Red cells (Initials) E. _____ Plasma (FFP) (Initials) F. _____ Other: _____ (Initials)

2. Statement of Refusal.

I, _____ direct **no transfusion** of product(s) initialed above be given to me even if health
(Printed Patient Name)
care providers believe only blood transfusion will improve my condition, extend or preserve my life.

3. Blood derivatives ("minor blood fractions"). Substances taken from one of the blood products listed above.
Examples: Albumin, immunoglobulins, and clotting factors.

_____ (Initials) I am **willing to consider*** medications or products that are or contain minor blood fractions. If I am unable to participate in my care, I understand these products may be used as needed.

_____ (Initials) I **absolutely refuse** medications or products that are or contain minor blood fractions even if health care providers believe they will improve my condition, extend or preserve my life.

4. Procedures that return the patient's blood to the patient.
Examples: "Cell salvage", hemodialysis, epidural blood patch.

INITIAL ONLY ONE OPTION

_____ (Initials) I am ***willing to consider**** procedures that return my own blood to me. If I am unable to participate in my care, my blood may be returned to me during a procedure.

_____ (Initials) I am ***willing to consider**** procedures that return my own blood to me provided the equipment handling my blood is kept in **constant connection** with me. If I am unable to participate in my care, my blood may be returned to me if the equipment handling my blood has not been disconnected.

_____ (Initials) I ***absolutely refuse*** the return of my own blood even if returning my blood will improve my condition, extend or preserve my life. If my blood leaves my body, the blood must be wasted.

* Points 3 & 4: Please discuss treatment options you are willing to consider with your health care provider(s).

Additional Instructions, if any: _____

Washington State law gives me the right and responsibility to make decisions about my health care. I understand there is no substitute for blood and accept the consequences of my refusal of blood products, including injury and death. I have had the opportunity for my questions to be answered by Swedish Medical Center (SMC) staff. I have read this document, fully understand its contents, and voluntarily sign it.

My refusal of blood products instructions will be reviewed with me at each hospital encounter at SMC. I may change my instructions or discontinue my refusal by informing SMC staff at any time.

☐ Yes - Interpreter was used as part of this process.

Signature (Patient or Legal Representative)	Print Name	Date	Time

Relationship (If other than Patient)

Witness to Signature	Print Name	Date	Time

PATIENT LABEL

SWEDISH
SEATTLE, WASHINGTON

1BLM

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