AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. *(Check all applicable boxes)*

	OPERATION OR PROCEDURE		SEDATION
	ANESTHESIA		TRANSFUSION

1b. DESCRIBE

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

BLOOD TRANSFUSION

which is to be performed by or under the direction of Dr. _____

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are: _____
(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes for medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

8. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and signif icant alternative therapies.

_____
(Signature of Counseling Physician/Dentist)

9. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

10. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____
sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no.(SSN or other); hospital or medical facility)*	REGISTER NO.	WARD NO.

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Medical Record

OPTIONAL FORM 522 (REV. 8/2003)
Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)

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INFORMED CONSENT FOR BLOOD PRODUCT ADMINISTRATION

1. During the course of your treatment you may need to receive blood products. The benefits of blood transfusion are highly individualized and are best explained by your physician.

2. Refusal to consent to a blood transfusion may put your health in danger by making you very anemic (low blood count), making your specific condition worse or increasing your risk during surgery.

3. While many precautions are taken to make blood products safe, there are some well-known risks, including, but not limited to those outlined below:

a. Transmission of an infectious bacterial, viral or parasitic disease such as: Babesiosis, bacterial sepsis, Chagas disease, Cytomegalovirus, Hepatitis B virus, Hepatitis C virus, HIV1 (AIDS), Human T-cell Lymphotropic Virus (HTLV 1 and 2), Malaria, Syphilis, or Yersinia.

b. Severe transfusion reactions caused by ABO incompatibility.

c. Allo-immunization or producing antibodies to the donor's antigens. This condition can result in hemolysis or inadequate response to transfusion.

d. Febrile and allergic transfusion reactions.

e. Graft vs. Host Disease (extremely rare).

f. Additional risks and/or complications including circulatory overload, iron overload, depletion or coagulation proteins and metabolic complications.

4. This hospital's laboratory performs extensive testing of donor products in order to minimize these important risks, but they cannot be entirely eliminated. Although extremely rare, complications may cause serious illness or death.

Blood components that you receive may be tested for infectious diseases using an investigational research method called nucleic acid testing (NAT). The NAT research tests are performed in addition to the FDA-required, routine tests for infectious diseases that are performed by all collection centers on every blood donation. This research is being conducted to help evaluate whether NAT should eventually be used as part of routine testing to further increase the safety of blood components that you receive. Blood components will continue to be released for transfusion based on results of required testing. As a result, blood components may sometimes be transfused before NAT is completed.

Very rarely, a blood component may have a NAT-reactive test result when the result of the required test for the same infectious disease was negative. Your attending physician will be notified if you have received a blood component that was suitable for transfusion based on currently required testing, but that later tested reactive by NAT research tests. Your physician will advise you of the implications of the NAT test result for your health and any treatment that may be appropriate.