Cabrini

Refusal of Blood or Blood Products

UR Number / Address _____

Surname _____

Given Names _____

DOB _____ Sex _____

Affix patient label here or complete details

FC01012 03

Interpreter used: ☐ No ☐ Yes Language / Interpreter service used: _____

Is anyone appointed as a person responsible[1] or are there written requests / instructions relating to care[2]? ☐ No ☐ Yes – must be filed in the medical record

To be completed by a Haematologist / Medical Practitioner with the patient / person responsible[1]

Where the patient / person responsible[1] indicates any refusal of blood or blood products an Advance Care Directive should also be completed.

Description of medical treatment, procedure or diagnosis that may require the administration of blood, blood products or blood related procedures:

Date of procedure (if known):

Primary Blood Components	Accept	Refuse	N/A	Procedures involving my own blood	Accept	Refuse	N/A
Red Blood cells				Cell Salvage			
Fresh Frozen Plasma (FFP, plasma)				Renal Dialysis			
Platelets				Plasmapheresis			
White cells (Granuloytes)				Blood Radio-labelling			
Cryoprecipitate							
Products containing a minor blood fraction	**Accept**	**Refuse**	**N/A**	**Recombinant products**	**Accept**	**Refuse**	**N/A**
Albumin				rFVIIa (Novoseven)			
Intravenous immunoglobulin				Erythropoietin			
Anti-D immunoglobulin				Other e.g. FVIII			
Prothrombin Complex Concentrate (PCC)				**Other (Please specify)**	**Accept**	**Refuse**	**N/A**
Other immunoglobulins e.g. Tetanus							

Reason for Refusal and Additional Comments: Please document the specific reasons or circumstances surrounding the refusal and any additional comments that may be relevant to the decision, including instructions or preferences in emergency or life-threatening situations where they differ from above.

Declaration of Medical Practitioner

I have discussed the need or potential need for blood or blood products with the patient / person responsible[1] and the risks of refusing such products. I have given the patient / person responsible[1] the opportunity to ask questions.

Full name: _____ Signature: _____ Date: _____

Declaration of Patient / Person Responsible[1]

I have discussed and documented my preferences regarding refusal or acceptance of blood or blood products with my doctor. This includes any instructions where my preferences differ in emergency or life saving situations. I can change my mind at any time, however, understand that the documented preferences will remain in force where I may be unconscious or incapable of expressing my wishes. I understand that where I have indicated acceptance of blood / blood products as above this constitutes my consent to recieving them.

Full name: _____ Signature: _____ Date: _____

1. A person responsible may include an appointed medical treatment decision maker under the Medical Treatment Planning and Decisions Act 2016 (Vic) or a guardian with power to make medical treatment decisions appointed under the Guardianship and Administration Act 2019 (Vic)
2. Advanced Care Directives including any Instructional directives or Values directives under the Medical Treatment Planning and Decisions Act 2016 (Vic) or similar document

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REFUSAL OF BLOOD OR BLOOD PRODUCTS MR002DR