HACKENSACK UNIVERSITY MEDICAL CENTER
30 Prospect Avenue
Hackensack, NJ 07601

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

Bloodless Medicine and Surgery Program Enrollment Form/ Treatment Option Checklist

I refuse Blood Transfusions. I refuse whole blood, red blood cells, white blood cells, platelets or plasma under any circumstances. I refuse transfusions of blood or any of its major components even in the event that a physician or his/her designee believes a transfusion is necessary to preserve my health or my life.

I fully understand and accept the risks involved in refusing blood transfusions. I have been provided with information regarding the alternatives to transfusion which are listed below and all of my questions have been answered.

With regard to the following treatment options, I have indicated those that are acceptable to me:

Treatment Options	Patient Wishes	
Fractions		
1. Albumin	☐ I accept	☐ I do not accept
2. Cryoprecipitate	☐ I accept	☐ I do not accept
3. Immunoglobins	☐ I accept	☐ I do not accept
4. Single clotting factors	☐ I accept	☐ I do not accept
5. Topical Tissue Adhesives (platelet gel, fibrin glue)	☐ I accept	☐ I do not accept
Procedures		
1. Acute Normovolemic Hemodilution	☐ I accept	☐ I do not accept
2. Blood Tagging	☐ I accept	☐ I do not accept
3. Cardiopulmonary bypass (Heart-lung machine)	☐ I accept	☐ I do not accept
4. Cell Salvage (Cell Saver)	☐ I accept	☐ I do not accept
5. Hemodialysis	☐ I accept	☐ I do not accept
6. Drain re-infusion of blood	☐ I accept	☐ I do not accept
Other (please specify) _____	☐ I accept	☐ I do not accept

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____