

Appendix B: General Consent Form excluding Blood Transfusion

GENERAL CONSENT FORM EXCLUDING BLOOD TRANSFUSION

Trust or Authority _____ Patient's Surname _____
 Hospital _____ Other Name (s) _____
 Unit Number _____ Date of Birth _____ Male ☐ Female ☐

DOCTOR—Please See Overleaf (*this part to be completed by Registered Medical Practitioner*)

TYPE OF OPERATION INVESTIGATION OR TREATMENT _____

I confirm that I have explained the operation investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/regional/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient. I further confirm that I have emphasised my clinical judgement of the potential risks to the patient and/or person who none-the-less understood and imposed the limitation of consent expressed below.

I acknowledge that this limited consent will not be over-ridden unless revoked or modified in writing.

Signature _____ Date _____

Name of Registered Medical Practitioner _____

PATIENT/PARENT/GUARDIAN—Please See Overleaf

I am ☐ the patient / parent / guardian (*delete as necessary*).

I agree (subject to the exclusions below)

- ☐ to what is proposed, which has been explained to me by the doctor named on this form.
- ☐ to the use of the type of anaesthetic that I have been told about.
- ☐ to the use of non-blood volume expanders; pharmaceuticals that control haemorrhage and/or stimulate the production of red blood cells.

I have told the doctor

- ☐ that I am one of Jehovah's Witnesses with firm religious convictions and that I have decided resolutely to obey the Bible command "keep abstaining from ... blood" (Acts 15:28, 29). With full realisation of the implications of this position, and exercising my own choice, free from any external influence, I expressly **WITHHOLD MY CONSENT** to the transfusion of **ALLOGENEIC BLOOD OR PRIMARY BLOOD COMPONENTS (RED CELLS, WHITE CELLS, PLASMA & PLATELETS)**, and to the use of any sample of my blood for cross-matching.
- ☐ that this limitation of consent shall remain in force and bind all those treating me unless and until I expressly revoke it in writing.
- ☐ about any additional procedures I would NOT wish to be carried out straightaway without my having the opportunity to consider them first.

I understand

- ☐ that the procedure might not be done by the doctor who has been treating me so far.
- ☐ that my express refusal of allogeneic blood or primary blood components will be regarded as absolute and will NOT be over-ridden in ANY circumstance by a purported consent of a relative or other person or body. Such refusal will be regarded as remaining in force even though I may be unconscious and/or affected by medication, stroke, or other condition rendering me incapable of expressing my wishes and consent to treatment options, and the doctor(s) treating me consider that SUCH REFUSAL MAY BE LIFE THREATENING.
- ☐ that any procedure in addition to the investigation or treatment described on this form, but with the exclusion of the transfusion of allogeneic blood or primary blood components, will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.
- ☐ that details of my treatment, and any consequences resulting, will not be disclosed to any source without my express consent or that of my instructed agent(s), unless required by law.

Signature _____ Date _____