REFUSAL TO PERMIT BLOOD TRANSFUSION

Date _____ Time _____ AM/PM

I request that no blood or blood products be administered to _____ during this hospitalization, even though such treatment may be necessary in the opinion of the attending physician or his assistants to preserve life or promote recovery. I release Medical City Plano, its personnel, and the attending physician from any responsibility for unfavorable results due to my refusal to permit the use of blood or blood products. I fully understand the possible consequences of my refusal.

Witness: _____ Date _____ Time _____ AM/PM

Patient: _____ Date _____ Time _____ AM/PM

If patient is a minor:

_____ _____ Date _____ Time _____ AM/PM

Parent/Guardian Relationship to Minor

Medical City Plano

3901 West 15th Street
Plano, Texas 75075
(972) 596-6800

PATIENT IDENTIFICATION

Refusal To Permit Blood Transfusion