REFUSAL TO CONSENT

For

TRANSFUSION OF BLOOD and/or BLOOD PRODUCTS

1. Dr. __________________________ and I have discussed the risks, including death, of not receiving blood and/or blood products.

2. I have been given information and have had the opportunity to ask the above named Doctor questions about the benefits and risks of blood and/or blood products. I am satisfied that all my questions have been adequately answered. I understand what has been discussed.

3. The above named Doctor and I have discussed the possibility of using treatments other than blood and/or blood products. I understand the benefits and risks of these alternative treatments, including the risks of not receiving blood and/or blood products.

4. I understand that the hospital, its personnel, and the attending doctors will not be responsible whatsoever for negative reactions, complications or unfavourable results, including death, due to my refusal to permit the use of blood and/or blood products.

5. For children under 18 years of age: I understand that if I/my child refuse(s) consent for blood and/or blood products the B.C. Ministry for Children and Families may be asked to become involved in accordance with Child Protection Legislation.

I understand this form and hereby refuse the administration of blood and/or blood products during my/my child’s treatment. I have the right to change my mind at any time regarding this refusal. However, I understand that there may be circumstances where it would be impossible to communicate the cancellation of this refusal, such as while unconscious during surgery.

PATIENT / GUARDIAN

<table>
<thead>
<tr>
<th>Name of Patient</th>
<th>Signature of Patient</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>And/or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of person legally qualified to give consent</td>
<td>Signature of person legally qualified To give consent</td>
<td>Date</td>
</tr>
<tr>
<td>Relationship to patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Witness to above signatures</td>
<td>Signature of Witness to above signatures</td>
<td>Date</td>
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</tbody>
</table>

PHYSICIAN

I have explained the benefits and risks of consent and refusal of transfusion therapy to the above mentioned patient and/or their parent/guardian.

<table>
<thead>
<tr>
<th>Name of Physician</th>
<th>Signature of Physician</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Witness</td>
<td>Signature of Witness</td>
<td>Date</td>
</tr>
</tbody>
</table>

Reason for Refusal (This section is optional)

- Religious
- Risk of Reaction
- Risk of Infection
- Previous adverse experience
- Other
- Did not state

This form will remain valid only for the duration of the treatment course.

White Copy: Health Records Chart
Yellow Copy: Ambulatory Clinic Chart/Physician’s Office/Other

Revised: September 1, 2000.