FORM 5-2

Refusal of Blood Products

I do not want the following to be administered to me during this hospitalization:

- ☐ Blood
- ☐ Blood derivatives
- ☐ Blood and blood derivatives

I hereby release the hospital, its personnel, the attending physician, and any other person participating in my care from any responsibility whatsoever for any injury or unfavorable consequences due to my refusing the use of blood or its derivatives.

The possible risks and consequences of my refusal have been fully explained to me by my attending physician. I fully understand the risks and consequences that may occur as a result of my refusal.

I understand that my attending physician and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Signature: _____
(witness)

Print name: _____
(witness)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 5-2S

Negativa a Recibir Productos Sanguíneos

Deseo que lo siguiente no me sea administrado durante esta intermación:

- ☐ Sangre
- ☐ Derivados de la sangre
- ☐ Sangre y derivados de la sangre

Por la presente, eximo al hospital, a su personal, al médico que me atiende y a otras personas que participen en mi atención de toda responsabilidad, sea cual fuere, por cualquier lesión o consecuencia adversa que se produzca por mi negativa a permitir el uso de sangre o sus derivados.

El médico que me atiende me explicó, en forma completa, los posibles riesgos y consecuencias de mi negativa. Entiendo completamente los riesgos y las consecuencias que se pueden producir debido a mi negativa.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente/representante legal)

En caso de que lo firmase una persona que no sea el paciente, indique la relación: _____

Nombre en letra de imprenta: _____
(representante legal)

Firma: _____
(testigo)

Nombre en letra de imprenta: _____
(testigo)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*