



Beaufort Memorial HOSPITAL

NO BLOOD Enrollment and Release of Liability Form

Print Patient Name

Date

Instruction to patient: Please read carefully, place your initials on the line next to **NO BLOOD** and sign below. Enrollment as a **NO BLOOD** patient is voluntary on your part and you may choose to rescind your participation at any time. This form is not intended to replace discussion with your physician or decisions made in your Advance Directive. You are encouraged to discuss any questions with your physician or the blood conservation coordinator before making your decision.

_____ **NO BLOOD**
Patient Initials

You are hereby notified that I **absolutely refuse allogenic blood** (another person's blood) and **my own banked blood** under **any** and **all** circumstances, no matter what my medical condition. This means, **no whole blood, no red cells, no white cells, no platelets or plasma** no matter what the consequences, even if health-care gives believe that only blood transfusion therapy will preserve my life or health.

I hereby release Beaufort Memorial Hospital, its parties, affiliates, its medical and nursing staff, its officers, agents and employees from any and all damages, costs, losses, claims or liability that might be caused by my choice to refuse blood, despite otherwise competent care. This directive shall be binding on my heirs, executors, and/or assigned health care agents.

Patient Signature

Witness Signature

Patient Print Name

Witness Print Name

Instruction to patient: At any time you may choose to rescind your enrollment as a **NO BLOOD** patient. Please, complete the below portion of this form.

You are hereby notified that I rescind my decision not to accept blood or blood components.

On _____

Date / Time

Patient Signature

Witness Signature

Patient Print Name

Witness Print Name



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