Franklin Medical Group, PC
Digestive Disease Center

60 Westwood Ave. Waterbury, CT 06708 (ph. 203-574-3007) (fax 203-573-1739)

Joel J. Garsten, M.D., F.A.C.P., F.A.C.G., A.G.A.F.
Albert R. Marano, M.D., F.A.C.P., F.A. C.G., A.G.A.F.
Michele Kaczmarczyk, PA

Matthew E. Cohen, M.D., F.A.C.P., A.G.A.F.
Bhupinder S. Lyall, M.D., F.A.C.P. .

REFUSAL TO PERMIT BLOOD TRANSFUSION

Date:_____

I request that no blood derivatives be administered to_____

during this hospitalization. I hereby release the hospital, its personnel, and the attending physician,

_____

from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives and I fully understand the possible consequences of such refusal on my part.

NAME OF PATIENT:_____

SIGNATURE OF PATIENT:_____

SIGNATURE OF PATIENTS SPOUSE:_____

WITNESS:_____

When patient is a minor or incompetent to give consent:

SIGNATURE OF PERSON AUTHORIZED TO CONSENT FOR PATIENT

PRINT:_____SIGNATURE_____

RELATIONSHIP TO PATIENT:_____