Patient Label

Patient Blood Management (PBM) & Bloodless Medicine

Personal Choice Advance Care Planning Worksheet

PART A: **SELECT ONLY ONE 'LEVEL'** by checking one box, then PRINT YOUR NAME on the line below it.

Both Level 1 and Level 2: I request efforts be made to prevent blood transfusions using PBM Standards, including anemia management if indicated.

☐ LEVEL 1 NO BLOOD:

I, _____

direct that **NO TRANSFUSIONS of Whole Blood, Red Cells, White Cells, Platelets, or Plasma (including Fresh Frozen Plasma/FFP)** be given to me, **UNDER ANY CIRCUMSTANCES, INCLUDING LIFE-THREATENING EMERGENCIES. I refuse to pre-donate and store my blood for later infusion.** **My personal choices are also indicated in 'Part B' below.**

If applicable, confirm your choices on this document match your most recent **NO BLOOD Advance Directive document and provide a copy.*

OR

☐ LEVEL 2 BLOOD CONSERVATION:

I, _____

direct that **NO TRANSFUSIONS of Whole Blood, Red Cells, White Cells, Platelets, or Plasma (including Fresh Frozen Plasma/FFP)** be given to me, **EXCEPT IN LIFE-THREATENING EMERGENCIES.** **My personal choices are also indicated in 'Part B' below.**

PART B: ***BOTH Level 1 and Level 2—please indicate all your choices regarding fractions/treatments/procedures/equipment below.***

	ACCEPT *(Initials)*	REFUSE *(Initials)*	
RED CELL FRACTIONS*			**HEMOGLOBIN**: Helps carry oxygen from the lungs through the body.
			HEMIN: Derived from Hemoglobin to treat rare genetic disorders.
WHITE CELL FRACTIONS*			**INTERFERONS/INTERLEUKINS:** Proteins that help fight infections. Also used in some cancer treatments.
PLASMA FRACTIONS*			**ALBUMIN:** A protein that helps to increase blood volume. ***Also present in some medications such as those that stimulate erythropoiesis, and Sealing Agents.***
			CLOTTING FACTORS: Used to help stop active bleeding. ***Examples: Thrombin, Fibrinogen, Prothrombin Complex Concentrate (KCENTRA), Antithrombin III, Humate-P, Factors VII, IX.***
			CRYOPRECIPITATE (Cryo): A concentration of clotting factors and coagulation proteins. **May contain Plasma; Type/Screen is required if accepted.**
			IMMUNOGLOBULINS (Antibodies): Proteins that help the body fight certain infections after exposure. ***If RhoGAM is accepted (ITP treatment and to determine Rh incompatibility in pregnancy), a Type/Screen is typically performed.***
			SEALANTS/GLUES and TISSUE ADHESIVES: Various combinations of fractions/coagulation proteins used to help stop surface bleeding during surgery; sometimes mixed with clotting factors (fractions) such as **Thrombin & Albumin.**
TREATMENTS, PROCEDURES, & EQUIPMENT* (using your own blood or fractions)			**CELL SALVAGE:** Filters and returns your blood collected during surgery. ***NOT primed with blood, blood NOT stored for later infusion, continuous circuit.***
			PLASMAPHERESIS/APHERESIS: Filters off your plasma and replaces with saline **or Albumin****.
			EPIDURAL BLOOD PATCH: Your blood is injected around your spinal cord to seal a leak.
			PLATELET GEL AUTOLOGOUS (Platelet-Rich Plasma-PRP): Your own clotting factors (plasma fractions) are used to help enhance wound healing.
			ACUTE NORMOVOLEMIC HEMODILUTION: Your blood is removed at initiation of surgery, replaced with fluids, then returned in an uninterrupted system at the end of surgery.
			HEART-LUNG MACHINE: A closed system pump that adds oxygen to your blood.
			HEMODIALYSIS MACHINE: Filters and cleans your blood, similar to the kidneys.
			CELL TAGGING/LABELING: Mixes your blood with a tracer and reinjects later for testing.
Other Specified Treatment(s)			***Please Specify:***
			Please Specify:

***For more details, refer to the '*PERSONAL CHOICE: Fractions/Treatments/Procedures/Equipment*' document, and discuss with your doctor and care providers.**

****If you DO NOT accept Albumin (see Plasma Fraction Section on this worksheet), please confirm your wishes with provider and care team.**

_____ ***I give no one any authority (including my family, friends, agent and or proxy) to override my instructions set forth herein.***

(Initials)

Patient Signature: _____ **Date:** _____ **Time:** _____

Witness Printed Name and Signature: _____ **Date:** _____ **Time:** _____