Potential Recipient Consent

I am requesting, with my doctor's permission, that I have directed donation(s) of blood or blood components collected by the Rock River Valley Blood Center (RRVBC).

My physician and I have discussed the risks involved by receiving a directed donation and the option of autologous blood donation (donating my own blood).

I have read RRVBC's position statement. I understand that there are risks involved such as infections from Hepatitis B, Hepatitis C, and HIV. There is also the risk of a fatal Graft-vs.-Host disease from a blood relative.

If I develop a transfusion related infection, I understand that RRVBC will **NOT** provide me with any information in order to identify the donor(s) that may have caused such an infection.

RRVBC will perform all required tests and procedures in order to maximize the safety of directed donor blood.

My signature indicates that I understand the information above. I have had a chance to ask questions and had my questions answered by RRVBC staff.

____ ________________________

Signature of Patient/Representative Date

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If Representative, Print Representative's Name, Relationship to Patient & Reason Patient is Unable to Sign

Name(s) of donor(s): ____

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