NO BLOOD

MEDI CAL DI RECTI VE

Advance Medical Directive / Release

I, ____, make this advance directive as a formal statement of my wishes. These instructions reflect my resolute decision.

I direct that *no blood transfusions* (whole blood, red cells, white cells, platelets, or blood plasma) be given to me under any circumstances, even if physicians deem such necessary to preserve my life or health. I will accept nonblood volume expanders (such as dextran, saline or Ringer's solution, or hetastarch) and other non-blood management.

This legal directive is an exercise of my right to accept or to refuse medical treatment in accordance with the federal Patient Self Determination Act and state law. I also know that there are various dangers associated with blood transfusions. So I have decided to avoid such dangers and, instead, to accept whatever risks may seem to be involved in my choice of alternative non-blood management.

I release physicians, anesthesiologists, and hospitals and their personnel from liability for any damages that might be caused by my refusal of blood, despite their otherwise competent care.

I authorize the person(s) named below to see that my instructions set forth in this directive are upheld and to answer any questions about my absolute refusal of blood.

*Patient Name:*____

*Address*____

*City:*____________________________________ *State:*________ *Zip*____________

*Signature*____ *Date:*______________

Witnesses' Statement:

I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older.

*Witness:*____

*Address:*____

____

*City:*________________________ *State:*_______ *Zip:*_________

*Signature:*______________________________ *Date:*_________

*Witness:*____

*Address:*____

____

*City:*________________________ *State:*_______ *Zip:*_________

*Signature:*______________________________ *Date:*_________

In case on emergency, please contact:

*Contact 1:*____

*Address:*____

____

*City:*________________________ *State:*_______ *Zip:*_________

*Phone:*__________________________________

alternate contact:

*Contact 2:*____

*Address:*____

____

*City:*________________________ *State:*_______ *Zip:*_________

*Phone:*__________________________________

For more information about bloodless care you may contact the Jehovah's Witness liaison at your local hospital or you may call the Center for Bloodless Medicine and Surgery at the Pennsylvania Hospital at (215) 829-6504. Prepared by Robert J. Romano, Jr., an Elder Law Attorney located in Paramus, New Jersey, in partnership with the Women's Heart Foundation. www.womensheartfoundation.org. *All Rights Reserved.* *Rev. 02/10/01.*

WOMEN'S HEART FOUNDATION