SickKids®
THE HOSPITAL FOR
SICK CHILDREN

J101

Addressograph

LAST NAME (FIRST)

DATE OF BIRTH SEX MRN
YY MM DD

ADDRESS

IMPRINT OR ENTER DETAILS BY HAND

LETTER OF UNDERSTANDING

JEHOVAH'S WITNESS PATIENTS AND BLOOD TRANSFUSION

TO BE PLACED AT THE FRONT OF THE CHART
UPDATE IF CHILD IS MOVED TO ANOTHER UNIT AND/OR RESPONSIBLE PHYSICIAN IS CHANGED.

For the care of _____

(Please print patient's name)

Caregivers at The Hospital for Sick Children recognize that parents or substitute decision makers of children who are Jehovah's Witnesses usually do not want their child to be given blood products. Knowing this, doctors will look for other reasonable ways to treat these children that do not require blood transfusions.

In an emergency, where your child is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm, medical staff will provide treatment that is allowed by the law, which may include blood transfusion.

Responsible physician/surgeon (or delegate) (Please print name) _____

Date (YYYY/MM/DD) _____ Time _____

Name of admitting unit _____

I have read and understand this letter. My signature is not agreement for blood transfusion or giving up my legal right to make medical decisions for my child.

Signature of parent or guardian (Please print patient's name) _____

Relationship to patient _____

Date (YYYY/MM/DD) _____ Time _____

Address of parent or guardian

Street _____

Apt. _____

City _____ Province _____

Postal Code _____

Phone number of parent or guardian _____