Consent To Blood Transfusion

1. Dr. _____________________________________________________________ at this healthcare facility, has informed me that I need or may need transfusion of blood and/or one of its products or derivatives in the interest of my health and proper medical care.

2. Dr. _____________________________________________________________ has described to me the risks and benefits of receiving transfusion of blood and/or one of its products or derivatives. These risks exist despite the fact that the blood has been carefully tested.

3. The alternative to transfusion, including the risks and consequences of not receiving this therapy have been explained to me.

4. I have had the opportunity to ask questions, and I consent to the transfusion(s).

Patient/Agent/Relative/Guardian* (Signature) Date / Time Print Name Relationship if other than patient

Telephonic Interpreter’s ID # Date / Time

OR

Signature: Interpreter Date / Time Print: Interpreter’s Name and Relationship to Patient

Witness to signature (Signature) Date / Time Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner’s Certification. I certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained the consent from the patient. If applicable, I certify that outside pathology slides have been reviewed by the Hospital’s Pathology Department.

Responsible Practitioner’s Signature Date / Time

Print Responsible Practitioner’s Name Contact Information

**Consent in outpatient setting will be valid for one year unless revoked.