Blood Product Transfusion Consent Form

Patient Name:

Date of Birth:

Medical Record Number:

Blood Product Transfusion Information

I have been informed about the need for blood product transfusion. The risks, benefits, and alternatives have been explained to me, and all my questions have been answered.

☐ I consent to receive blood product transfusion.

Signature

Patient/Legal Guardian Signature:

Date:

Physician Name:

Physician Signature:

Date: