Surgical Blood Transfusion Authorization Form

Patient Name:

Date of Birth:

Patient ID/Record Number:

Surgical Procedure:

Attending Physician:

Date of Surgery:

Authorization

I hereby authorize the administration of blood and/or blood products as deemed necessary by my physician for the above-mentioned surgical procedure. I acknowledge that the risks, benefits, and alternatives have been explained to me.

Patient/Guardian Signature:

Relationship to Patient (if applicable):

Date: