

Blood Transfusion Consent Agreement

I hereby consent to the administration of blood or blood products as deemed necessary by my physician and healthcare team. I understand the reasons for transfusion, the potential risks, alternatives, and have had the opportunity to ask questions.

Patient Information

Full Name:

Date of Birth:

Patient ID Number:

Consent Declaration

I have read and understand the information provided and voluntarily consent to the blood transfusion.

Signature

Patient/Guardian Signature:

Date:

Witness

Witness Name:

Date: