Signed Consent for Blood Transfusion

Patient Name:

Date of Birth:

Hospital/Clinic Name:

Explanation Provided
I have been informed about the nature, purpose, benefits, and risks of receiving a blood transfusion. I understand the alternatives and have had the opportunity to ask questions.

☐ I understand the risks and benefits of blood transfusion.

☐ I voluntarily consent to receive a blood transfusion as determined necessary by my healthcare provider.

Patient/Guardian Signature:

Date:

Witness Signature:

Date:

Physicianâ€™s Name:

Physicianâ€™s Signature:

Date: