Patient Blood Transfusion Permission Form

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Consent Statement

I hereby authorize and consent to receive blood transfusion(s) as deemed necessary for my medical care. The benefits, risks, and alternatives to transfusion have been explained to me by my healthcare provider.

☐ I have read and understand the above and agree to the blood transfusion.

Patient/Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

Submit