

Preoperative Blood Transfusion Consent Form

Patient Name:

Date of Birth:

Hospital/Institution:

Physician:

Description:

I understand that a blood transfusion may be necessary during or after my surgery. I have been informed of the benefits, risks, and possible alternatives to blood transfusion.

Consent:

I consent to receive blood and/or blood products as deemed necessary by my healthcare providers.

Patient or Legal Guardian Signature:

Date:

Witness Signature:

Date: