

# 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:**