Blood Transfusion Consent Form

Patient Information

Full Name:

Date of Birth:

Patient ID/Medical Record No.:

Explanation and Consent

Please read the following before providing consent:

- [ ] I have been informed about the reason and possible benefits for blood transfusion.
- [ ] I understand the potential risks and complications, such as allergic reaction, infection, fever, and others.
- [ ] I am aware of alternative treatment options, if any, and have had the opportunity to discuss them.
- [ ] I had the opportunity to ask questions, and my questions have been answered to my satisfaction.

Comments or Special Instructions (optional)

Consent & Authorization

I hereby consent to receive transfusions of blood and/or blood products as recommended by my physician. I understand the information I have received and agree to the proposed treatment.

Patient/Guardian Signature

Date

Physician/Witness Signature

Date