Consent for Blood Transfusion

Patient Information

| Patient Name: |
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| |
| Date of Birth: |
| |
| Medical Record Number: |
| |
| Date: |
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| Consent |
| I hereby give my consent to receive a blood transfusion and have had the risks, benefits, and alternatives explained to me. |
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| Patient/Representative Signature: |
| |
| Date: |
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| |
| Witness Signature: |
| |
| Date: |
| |
| |
| Physician Signature: |
| |
| Date: |
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