Blood Transfusion Consent Form

Patient Information

Full Name

Date of Birth

Patient ID / Medical Record Number

Consent

I hereby consent to the transfusion of blood or blood components as considered necessary by my healthcare provider.

Information Provided to Patient (Risks/Benefits/Alternatives)

Declaration

Patient / Legal Guardian Declaration

Signature of Patient / Legal Guardian

Date

Physician / Health Care Provider Declaration

Signature of Physician / Provider

Date