Acute Blood Loss Surgery Consent Form

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

Date: _____

Diagnosis

Surgical Procedure

Indication for Surgery

Nature of Surgery

Risks and Complications Associated with the Procedure

â€” Acute blood loss
â€” Need for blood transfusion
â€” Infection
â€” Bleeding
â€” Damage to surrounding organs

Benefits and Alternatives

Consent

I have read and understood the information above. I have had the opportunity to ask questions and my questions have been answered. I consent to undergo the proposed surgery and acknowledge the potential risks and alternatives.

Patient/Legal Guardian Signature: _____

Date: _____

Physician Signature: _____

Date: _____