

**Consent to Transfusion  
Of  
Blood or Blood Products**

Addressograph

Patient: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  AM /  PM

1. Blood Transfusion: It has been explained to me that I need or may need a blood transfusion and/or blood products for the following reason: \_\_\_\_\_  
I understand in general what a transfusion is and the procedures that will be used.
2. Risks: It was also explained to me that there are possible risks involved with this blood transfusion including, but not limited to, transfusion of infectious hepatitis, acquired immune deficiency syndrome (AIDS), or certain other diseases, unexpected blood reactions, such as immunization or allergic reactions.
3. Alternatives: Alternatives to blood transfusion and/or blood products, including the risks and consequences of not receiving this therapy, have been explained to me.
4. Patient consent: I accept all the risks explained and hereby authorized the administration of such transfusion or transfusions of blood or blood products to me in connection with my medical and surgical care as may be deemed advisable in the judgment of my attending physician or said physician's associates or assistants.

No Guarantee: While extensive testing is performed on all blood used for transfusions, no testing is 100 percent (100%) reliable. I acknowledge that no guarantees have been made to me about the outcome of the transfusion.

If you have any questions as to the risks or hazards of blood transfusions, or any questions concerning the proposed procedure or treatment, ask your physician NOW, before signing this consent form.

Do not sign unless you have read and thoroughly understand this form.

Consent Form will be valid for 30 days or one admission, whatever comes first.

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient Signature

The patient is unable to consent because: \_\_\_\_\_  
I, therefore, consent for this patient.

\_\_\_\_\_  
Relative/Guardian/Representative

\_\_\_\_\_  
Relationship to Patient

As the physician ordering the transfusion/s, I have explained the risks, benefits, and alternatives of blood or blood product transfusions to this patient.

\_\_\_\_\_  
Physician Signature

**Refusal of Consent to Transfusion  
Of  
Blood or Blood Products**

Addressograph

I, \_\_\_\_\_, do refuse to consent to the transfusion of blood and/or blood products described on this consent form. The risks attendant to my refusal have been fully explained to me, and I hereby release the YOUR Medical Center, its nurses and employees, together with all physicians in any way with me as a patient, from liability for respecting and following my express wishes and direction.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient or Responsible Person

AM  
PM

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Relationship to Patient