

HEALTHCARE

## CONSENT FOR TRANSFUSION OF BLOOD OR BLOOD PRODUCTS

I authorize the transfusion of whole blood or blood products as may be deemed advisable in the judgment of my physician(s).

My physician, \_\_\_\_\_, has discussed my need for transfusion of whole blood or blood products as well as the procedure and the risks and benefits of transfusion. I understand the risks and benefits of alternative options available to me, including the decision to not be transfused. I have had the opportunity to ask questions and all my questions are answered.

I understand this consent to be valid for all transfusions needed during my hospitalization or for outpatient conditions requiring multiple transfusions over the next year.

\_\_\_\_\_  
Signature of Physician Obtaining Consent

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date and time

\_\_\_\_\_  
Relation to Patient