Consent To Blood Transfusion

1. Dr./ACP _____ at this healthcare facility, has informed me that I need or may need transfusion of blood and/or one of its products or derivatives in the interest of my health and proper medical care.

2. Dr./ACP _____ has described to me the risks and benefits of receiving transfusion of blood and/or one of its products or derivatives. These risks exist despite the fact that the blood has been carefully tested.

3. The alternative to transfusion, including the risks and consequences of not receiving this therapy have been explained to me.

4. I have had the opportunity to ask questions, and I consent to the transfusion(s).

_____ _____ _____ _____
Patient/Agent/Relative/Guardian* (Signature)   Date   Time   Print Name   Relationship if other than patient

_____ _____ _____
Telephonic Interpreter's ID #   Date   Time
      OR

_____ _____ _____ _____
Signature: Interpreter   Date   Time   Print: Interpreter's Name and Relationship to Patient

_____ _____ _____ _____
Witness to signature (Signature)   Date   Time   Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner's Certification. I certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained the consent from the patient. If applicable, I certify that outside pathology slides have been reviewed by the Hospital's Pathology Department.

_____ _____ _____ _____
Responsible Practitioner's (Signature)   Date   Time   Contact Information

_____
Print Responsible Practitioner's Name

**Consent in outpatient setting will be valid for one year unless revoked.