

**CONSENT FOR  
BLOOD TRANSFUSION**

**SH 419BT MR**



\*50\*

- Inpatient
- Outpatient
- ED

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

RR DONNELLEY

**Reason for and Benefit of Transfusion**

A transfusion is used to increase the ability of blood to carry oxygen or to replace blood components.

**Risks of Transfusion**

No transfusion is 100% safe, however present testing methods make the risks very small. Infection from viruses, bacteria or parasites, including but not limited to HIV (AIDS virus) and hepatitis are known risks. Other risks include fever, chills, allergy, volume overload or death.

**Alternatives**

Alternatives include: No transfusion, autologous transfusion (donation of my own blood), designated/directed donor transfusion (collection of blood from donors selected by me) or blood salvage (recycling of blood lost during an operative procedure). I understand that these alternatives may not be available to me due to timing or health reasons and that the above risks still may apply.

**Patient Consent**

I have had a chance to discuss the risks, benefits and alternatives regarding transfusion with my health care provider. I consent to the transfusion of blood or blood components. I understand this covers my present hospitalization and/or my outpatient course of treatment.

_____ Signature of Patient	_____ Appropriately Credentialed Provider	_____ Date / Time
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_____ Relationship (If Signed by Authorized Representative)	_____ Date / Time
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SMH - Consents  
HH - Consents

If patient is unable to sign or is a minor, complete the following:

- Patient is a minor ( \_\_\_\_\_ years of age)
  - Patient is unable to sign because \_\_\_\_\_
- \_\_\_\_\_

_____ Signature of Parent, Proxy or Guardian	_____ Attending Physician or Designee	_____ Date / Time
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