

**BLOOD OR BLOOD COMPONENTS  
CONSENT FORM**

**SECTION A: CONSENT FOR THE TRANSFUSION OF BLOOD OR BLOOD COMPONENTS**  
TO BE COMPLETED BY PATIENT/LEGAL REPRESENTATIVE, PHYSICIAN OR MIDLEVEL  
PROVIDER AND A WITNESS\*

I hereby authorize and consent to the transfusion of blood or blood components during the treatment of \_\_\_\_\_ at NCBH. I hereby acknowledge that I understand the following:  
(Patient's Name)

1. I understand that I need or may need a transfusion of blood or one of its components in the interest of my health and proper medical care. I understand what a transfusion is and the procedures that will be involved.
2. Although the blood has been carefully tested, I understand there are possible risks such as unexpected blood reactions or transmission of viral hepatitis, AIDS, and other infectious agents.
3. Alternatives to blood transfusion, if any, have been explained to me.
4. I understand that no guarantee as to the outcome of these transfusions has been made.
5. I understand that I may revoke this consent for a transfusion at any time.

I acknowledge that I have read this form or have had it read to me, that I understand it, and have had all my questions answered.

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN OR MIDLEVEL PROVIDER

\_\_\_\_\_  
PATIENT'S SIGNATURE/LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE & TIME

\_\_\_\_\_  
Witness\* (Witness signature is necessary only if patient signs with a mark (i.e. "X") or if consent obtained via the phone)

**SECTION B: DOCUMENTATION OF NEED FOR EMERGENCY TRANSFUSION**  
TO BE COMPLETED BY THE TREATING PHYSICIAN

I, the treating physician(s) have determined that there is an emergent need (\_\_\_\_\_) Specify the nature of the emergency

For transfusion and the patient is unable to consent (\_\_\_\_\_) Specify nature of the mental/physical incapacity

and the patient's representative is unavailable.

\_\_\_\_\_  
PRINTED NAME OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE & TIME

\_\_\_\_\_  
PRINTED NAME OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE & TIME

\*(Second physician signature needed only for emergency transfusions or pediatric patients)

