

**DOYLESTOWN HOSPITAL  
DOYLESTOWN, PA**

**Consent to Transfusion of Blood/Blood Products/Autologous Blood**

Patient's Name: \_\_\_\_\_

Dr. Dinesen, Dr. Ware, or Kamela King has explained to me that I may need a transfusion of blood/blood products for the following reasons:

\_\_\_\_\_  
\_\_\_\_\_

It has been explained to me, and I understand what blood/blood component transfusions are and what procedures will be used. The associated risks and possible complications of the procedure have also been explained to me. For elective surgery: I am aware that I have the option to be transfused with my own blood/blood components (or that of a family member or friend) that have been donated prior to my surgery.

I am aware that the blood/blood components have been screened for hepatitis, HIV (connected with the AIDS virus), and certain other communicable conditions by currently accepted methods. I understand that no warranties of any kind, expressed or implied, or merchantability, fitness or quality, or otherwise in connection with the transfusion of products are made.

I authorize and consent to the administration of blood/blood components and such additional transfusions as may be deemed advisable in the judgment of Dr. Dinesen or his assistants.

Signature of Patient: \_\_\_\_\_

Date/Time: \_\_\_\_\_

The patient is unable to consent because:

\_\_\_\_\_  
\_\_\_\_\_

I give consent for the patient because:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Person authorized to consent  
For the patient

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Relationship

I have personally explained the above information to the patient or the patient's representative.

Signature of Physician obtaining consent: \_\_\_\_\_

Date/Time: \_\_\_\_\_