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: _____