



The Mount Sinai Hospital
 One Gustave L. Levy Place
 New York, New York 10029

MRN -
 V -

Date

Name

Unit #

Sex/OOB

Physician Service

TRANSFUSION CONSENT FORM

1. Physician/Provider _____ has informed _____
 (Name of Patient or "Me")

that I need or may need a transfusion of blood and/or one of its products in the interest of my health and proper medical care.

2. The physician/provider above has fully explained to me in language I understand the nature of the proposed transfusion and has also informed me of the potential benefits and risks or side effects, including potential problems that might arise during recuperation, as well as the likelihood of achieving the proposed goals. I have been informed about reasonable alternatives of the proposed transfusion, the relative benefits and risks or side effects related to such alternatives, as well as the risks of not receiving the transfusion. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

Patient, Relative, or Guardian* _____
 Print Name Signature Date / Time (Relationship)

Signature Witness _____
 Print Name / Title Signature Date / Time

I _____ hereby certify that I have explained the nature, purpose, benefits, risks of, and
 (Physician/Provider)
 alternatives to, the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered. 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.

 Print Name Physician/Provider Signature Date / Time Dict #

* The signature of the patient must be obtained unless the patient is under the age of 18 or incompetent.
 NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.

