



Patient Identification

**QUINTE HEALTHCARE CORPORATION**

**CONSENT TO BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS**

- I consent to receive donor blood, and/or blood products manufactured from donor blood
- I REFUSE to receive blood and/or blood products manufactured from donor blood

I acknowledge that the nature of the treatment(s), the expected benefits, material risks, material side effects, alternative course of action and the likely consequences of not having the treatment(s) have been discussed with me and all questions have been answered to my satisfaction. I further acknowledge that I have the right to ask my physician further questions at any point during the course of my treatment and that my treatment should be delayed until these questions are answered.

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**Date YYYY/MM/DD**

\_\_\_\_\_  
**Signature of Substitute Decision Maker**

\_\_\_\_\_  
**PRINT NAME**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date YYYY/MM/DD**

*References: QHC Policy 3.1.1 Blood – Blood /Blood Product Utilization Guidelines  
QHC Policy 3.1.2 Blood – Blood/Blood Product Verification, Request and Monitoring*