
	All India Institute of Medical Sciences, Rajkot Department of Transfusion Medicine	
	BLOOD STORAGE UNIT License No. G/BSC/288 PATIENT CONSENT FORM FOR BLOOD TRANSFUSION	

I, Mr./Mrs./Miss _____ son/daughter/wife of _____ admitted under
(Physician/ surgeon's name) _____ in the department of _____
_____ for _____ disease.

I have been explained in a language that I understand that:

1. I / My patient's condition/ surgery/ therapeutic procedure requires the possibility of blood/ blood component transfusion.
2. I / My patient understand that the blood/blood component has been prepared and tested in accordance with rules established under the national regulations.
3. I / My patient has been explained the benefits as well as risks (including the transmission of HIV, Hepatitis B, Hepatitis C, syphilis/malaria and other transfusion related adverse events) of such transfusion. I understand that these risks remain despite the testing mentioned in point no 2.
4. I / my patient has also been explained the alternatives to transfusion and their benefits and limitations.
5. I / My patient had the opportunity to ask any questions/clarifications related to the need/benefits/risks/ alternatives to transfusion.
6. I / My patient believe that i/we have been sufficiently informed to decide to give consent for transfusion of blood or blood component.

I / My patient consent to the transfusion of blood and blood component as deemed necessary by the treating physician/surgeon.

(Signature/left thumb impression)

Patient / Pt. Representative
Name: _____

Date: _____

Place: _____

Signature: _____

Doctor name: _____

Date: _____

Place: _____

(Signature/left thumb impression)

Witness name: _____

Relation to patient: _____

Date: _____

Place: _____