

患者氏名 :
患者 ID :

Consent Form for Blood Transfusion

If you agree to have a blood transfusion, please sign below.

I have received a thorough explanation about blood transfusions and their risks by reading “Information about Blood Transfusions”, and I understand the content. I have also confirmed the details described below in the “types and amount of scheduled blood transfusions”. As a result, I agree to have a blood transfusion. (Even after you sign, you can withdraw your agreement at any time.) I also agree that my blood transfusion may be cancelled based on my doctor’s decision, and that the details of my blood transfusion may be changed from those described below in the “types and amount of scheduled blood transfusion” based on my doctor’s decision in case of a life-threatening emergency or if my doctor decides that a blood transfusion is necessary during my treatment.

■Types and amount of scheduled blood transfusion

1. Types: My own blood Red cell products Platelet products
 Fresh frozen plasma Other ()

2. Amount: _____ (ml)

Date of agreement (YYYY/MM/DD): _____ / _____ / _____

Patient’s name : _____ (print)

Patient’s signature : _____

Patient’s address : _____

Representative’s name : _____ (print)

Representative’s signature : _____ (relationship to patient: _____)

Representative’s address : _____

If you refuse to have blood transfusion, please read the following statement. If you understand it, please sign below.

I have received an explanation of the necessity of a blood transfusion; however, I refuse to have a blood transfusion. I will not hold my doctor or hospital liable regarding the consequences of my decision.

Date of signature (YYYY/MM/DD): _____ / _____ / _____

Patient’s name : _____ (print)

Patient’s signature : _____

Patient’s address : _____

Representative’s name : _____ (print)

Representative’s signature : _____ (relationship to patient: _____)

Representative’s address : _____

I provided the explanation about blood transfusion to the person who signed above.

Date of explanation (YYYY/MM/DD): _____ / _____ / _____ **Department:** _____

Attending doctor: _____ **Seal**

I confirm that the patient (or his/her representative) above has agreed or refused to have a blood transfusion by signing this document.

Date of confirmation (YYYY/MM/DD): _____ / _____ / _____ **Department:** _____

Attending doctor: _____ **Seal**

*If the patient is a minor who does not have the ability to agree, or cannot agree and sign because of a lack of consciousness or other medical condition, the signature in the “Representative” section above must be provided by a parent, guardian, responsible adult, or relative.