Northwell℠
Long Island Jewish Medical Center

Consent To Blood Transfusion

1. Dr./ACP _____ at this healthcare facility, has informed me that I need or may need transfusion of blood and/or one of its products or derivatives in the interest of my health and proper medical care.

2. Dr./ACP _____ has described to me the risks and benefits of receiving transfusion of blood and/or one of its products or derivatives. These risks exist despite the fact that the blood has been carefully tested.

3. The alternative to transfusion, including the risks and consequences of not receiving this therapy have been explained to me.

4. I have had the opportunity to ask questions, and I consent to the transfusion(s).

_____	_____	_____	_____	
Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient
_____	_____	_____		
Telephonic Interpreter's ID #	Date	Time		
OR				
_____	_____	_____	_____	
Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient	
_____	_____	_____	_____	
Witness to signature (Signature)	Date	Time	Print Witness Name	

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner's Certification. I certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate. 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. If applicable, I certify that outside pathology slides have been reviewed by the Hospital's Pathology Department.

_____	_____	_____	_____
Responsible Practitioner's (Signature)	Date	Time	Contact Information

_____
Print Responsible Practitioner's Name

**Consent in outpatient setting will be valid for one year unless revoked.

VD002 (11/07/2024)