

**CONSENT FOR ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS
USED FOR PATIENTS WITHOUT SURGICAL CONSENT FORM**

TO THE PATIENT, LEGAL GUARDIAN, LEGALLY AUTHORIZED REPRESENTATIVE, or CLOSEST RELATIVE. You have the right to be informed about the transfusion of blood, blood components and derivatives so that you may make the decision whether or not to have the transfusion after understanding the risks and benefits involved.

I hereby request and authorize the transfusion of blood or blood derivatives to

and such additional transfusions during this hospital

Printed name (first, last) of patient or "myself"

visit as may be deemed advisable in the judgment of

Printed name (first, last) of physician or other authorized practitioner

I have been given the opportunity to ask questions and the physician or authorized practitioner has explained the need for the transfusion, alternative forms of treatment, and risks involved. I believe that I have sufficient information to give this informed consent. (If declined, complete form N-730, "Refusal to Permit Blood Transfusion").

Signature of Patient

Time

Date

Signature of Witness

Time

Date

Telephone Discussion by physician or other authorized practitioner:

If patient, legal guardian, legally authorized representative or closest relative was informed of the above by a physician or other authorized practitioner by means of telephone discussion:

Nurse Signature

Time

Date

**If patient is unable to sign or is a minor, complete the following: Patient is (a minor ____ years of age)
OR is unable to sign because: _____**

Signature of Legal Guardian, Legally Authorized Representative or Closest Relative

Time

Date

Signature of Witness

Time

Date

Signature of Physician or Authorized Practitioner

Time

Date

Patient Label
placed here

**WakeMed
Consent for Administration
of Blood and Blood Products**



**PERMISO PARA ADMINISTRACIÓN DE SANGRE O PRODUCTOS DE SANGRE USADOS
PARA PACIENTES SIN FORMULARIO DE PERMISO PARA OPERACIONES**

AL PACIENTE, GUARDIÁN LEGAL, OTRO REPRESENTANTE AUTORIZADO LEGALMENTE o: FAMILIAR MÁS CERCANO: Usted tiene el derecho de ser informado sobre transfusiones de sangre o componentes y derivados de sangre, para que pueda tomar decisiones de si debe o no aceptar la administración de transfusiones una vez que haya entendido los riesgos y beneficios involucrados.

Por este medio solicito y autorizo la transfusión de sangre o de derivados de sangre a

Imprima el nombre del paciente o indique "a mi mismo"

y transfusiones adicionales que sean necesarias durante esta estadía en el hospital, según lo juzgue necesario el médico que ordene la sangre, o aquellas personas que estén designadas para asistirlo.

Printed name (first, last) of physician or other authorized practitioner

He tenido la oportunidad de hacer preguntas y el médico me ha explicado la necesidad de la transfusión, otras alternativas de tratamiento y los riesgos involucrados. Creo que tengo suficiente información para dar este permiso informado. (Si reúsa, llene el formulario N-730, "Negación de Permiso para Transfusiones de Sangre")

Firma del paciente

Hora

Fecha

Firma del testigo

Hora

Fecha

Telephone Discussion by physician or other authorized practitioner:

If patient, legal guardian, legally authorized representative or closest relative was informed of the above by a physician or other authorized practitioner by means of telephone discussion:

Nurse Signature

Time

Date

Si el paciente no puede firmar o es un menor de edad, complete lo siguiente: Paciente es (un menor, tiene _____ años de edad) O no puede firmar porque: _____

Firma del guardián legal, representante autorizado legalmente o pariente más cercano.

Hora

Fecha

Firma del testigo

Hora

Fecha

Signature of Physician or Authorized Practitioner

Hora

Fecha

Patient Label
placed here

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