嘉　　諾　　撒　　醫　　院
CANOSSA HOSPITAL (CARITAS)

Name _____
Age _____ Sex _____
Ward / Bed No. _____ Hospital No. _____

CONSENT BY PATIENT FOR TRANSFUSION OF WHOLE BLOOD OR BLOOD COMPONENTS

(1) I, *(insert patient's name)* _____ (the "Patient"), hereby voluntarily give my consent to receive transfusion of whole blood or blood components (the "Procedure"), as recommended and advised by Dr. *(insert name of doctor)* _____ (the "Doctor").

OR

I, *(insert name of person giving consent on behalf of the patient)* _____ the father/ mother/Guardian *(delete as appropriate) of (insert name of the patient)*_____ (the "Patient"), hereby voluntarily give my consent for the Patient to receive transfusion of whole blood or blood components (the "Procedure"), as recommended and advised by Dr. *(insert name of doctor)* _____ (the "Doctor").

(2) I acknowledge that, before signing this consent form, I have been fully informed about the nature, purpose and effect of the purposed Procedure, and also the potential risks of complications, side effects and reactions. I confirm that I fully understand the explanation that I have been given and that I accept the risks of complications, side effects and reactions.

(3) I confirm that I have been provided with an information leaflet on the Procedure (❑ copy given) and that I understand its contents.

_____ _____
Patient/Parent/Guardian's Name in block letter　　Witness' Name in block letter

Signature: _____　　Signature : _____

ID/Passport No.: _____

Date:_____　　Date: _____

DOCTOR'S DECLARATION: I have explained the nature, purpose and effect and also the possible risks of complications, side effects and reactions of transfusion of whole blood or blood components to the Patient / Parent / Guardian *(delete as appropriate)* and have answered the Patient's / Parent's / Guardian's *(delete as appropriate)* questions to his/her satisfaction.

_____　　Signature : _____
Doctor's Full Name in block letter

Date: _____

INTERPRETER

I, *(insert name of interpreter)* _____, certify that I have truly, distinctly and audibly interpreted the contents of this document into *(insert language or dialect)* _____ to the Patient / Parent / Guardian *(delete as appropriate).*

_____　　Signature: _____
Interpreter's Name in block letter

Date: _____