

**For staff use only:**

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_

Use hospital identification label

**Consultant:**

# Supplementary Consent Form

Supplementary consent to investigation or treatment by patient  
who refuses to have a blood transfusion

Please use 'Procedure completed'  
stamp below on completion:

**Important note:**

To be completed and attached to the consent form *Patient agreement to investigation or treatment*.

**For staff use only:**

Hospital number:

Surname:

First names:

Date of birth:

NHS no: \_ \_ \_ / \_ \_ \_ / \_ \_ \_ \_

Use hospital identification label

# Supplementary Consent Form

## Consultant or other responsible health professional

**Name and job title:** .....

Special requirements .....  
(For example, other language/other communication method)

**I** ..... **of** .....

hereby give my consent to the performance upon me of the operation/procedure of

The nature and purpose of which have been explained to me by

Dr / Mr .....

and to the administration of general, local or other anaesthetic. I also give my consent to the performance upon me of any other operative procedure which in the opinion of the surgeon it may be necessary to perform upon me, without having obtained my express consent, during or by reason of the said operation/procedure or anything connected with it; except that, although it has been explained to me that in the course of or by reason of the said operation/procedure it may be necessary to give me a blood transfusion (red cells, white cells, plasma or platelets) so as to render the operation/procedure successful, or to prevent injury to my health, or even to preserve my life.

I hereby expressly withhold my consent to and forbid the administration to me of a blood transfusion in any circumstances or for any reason whatsoever and I accordingly absolve the surgeon, the hospital and every member of the medical staff concerned from all responsibility, and from any liability to me, or to my estate, or to my dependants, for any damage or injury which may be caused to me, or to my estate or to my dependants, in any way arising out of or connected with this my refusal to consent to any such blood transfusion.

**I understand** that you cannot give me a guarantee that a particular person will perform the operation/procedure. The person will, however, have appropriate experience.

**Signed** (patient): ..... Date: **DD/MM/YYYY**

**Witness to Patient's Signature** (signed): ..... Date: **DD/MM/YYYY**

**Name of witness** (PRINT): .....

**Address:** .....

(Witness present at interview)

**Signed** (Health professional): ..... Date: **DD/MM/YYYY**

**Name** (PRINT): ..... Time (24hr): **..H..H.:M.M.**

**Designation:** ..... Contact/bleep no: .....

**Note:** please ensure this is attached to the patient's consent to the investigation or treatment.