Patient Information and Consent Form

Please email the completed form to kberrier@medicblood.org.

Patient’s Full Name:

Patient’s DOB: Last 4 Digits SSN:

Hospital where blood was received:

Patients’ Mailing Address:

Patient/Guardian Phone: Patient/Guardian Email:

Guardian’s Name (if patient is a minor):

Patient/Guardian’s Employer: Guardian’s DOB:

Spouse Name: Spouse DOB:

Spouse Phone: Spouse Email:

Spouse’s Employer:

Secondary/Blood Drive Contact Name:

Secondary/Blood Drive Contact Email:

*I have read and understood MEDIC’s patient support program information and guidelines. By signing this form, I agree that MEDIC may use the patient’s name, picture, or general information for marketing purposes.*

Patient/Guardian/Representative Name Date

Patient/Guardian/Rep. Signature Relationship to Patient

*For MEDIC Personnel Only:*

Patient ID #

Patient Information Received and Entered:

Date Entered:

Recruitment Manager Review:

Account Assigned to: