Onsite Phlebotomy Solutions

Patient Information and Consent

Blood collection and eye drop services

Please complete your information and select the service you are authorizing. Read both pages before signing. The eye drop section applies only when that service is selected.

Patient information

Full name _____

Date of birth _____ Gender optional _____

Home address _____

City state and ZIP _____

Email _____ Telephone _____

Service requested

☐ Blood collection for laboratory testing

☐ Blood collection and preparation or dispensing of prescribed eye drops made from my own blood including serum or platelet-rich plasma PRP eye drops

Prescribed eye drop type _____

Ordering or prescribing clinician _____

Clinician telephone _____ Order date _____

Consent to blood collection

I voluntarily authorize Onsite Phlebotomy Solutions personnel to collect my blood at my home or at the Onsite Phlebotomy Solutions office for the service selected above. I understand that a needle will be inserted into a vein. Risks include pain or discomfort, bruising, bleeding, dizziness or fainting, and infection. More than one attempt may be needed.

I will tell the person collecting my blood about relevant allergies, medications that affect bleeding, a bleeding disorder, anemia, prior fainting or problems with blood collection, and any restrictions affecting the collection site. Staff may postpone or stop the collection if it cannot be completed safely.

I may ask questions, decline the procedure, or ask staff to stop before or during collection. If I decline or stop, the requested testing or eye drop service may need to be delayed or an alternative discussed with my clinician.

Continue to the next page

Consent and signatures are on page 2. Selection of a service here does not replace the discussion needed with the treating clinician.

Consent for Eye Drop Services

Complete this section only if eye drop services were selected on page 1.

Patient name _____ Date of birth _____

Purpose and authorization

This consent covers prescribed eye drops made from my own blood, including serum eye drops and platelet-rich plasma (PRP) eye drops. These are different preparations. My prescribing eye care clinician will identify the preparation ordered, determine whether it is appropriate for my eye condition, and specify the treatment plan. The intended benefit is to help manage the eye condition discussed with that clinician; improvement is not guaranteed.

I authorize Onsite Phlebotomy Solutions to collect my blood and perform the preparation or dispensing described in my clinician's order, according to the applicable clinical protocol. This consent covers my own blood only and does not authorize the use of donor blood, research, or unrelated treatments.

Risks and treatment choices

In addition to the blood collection risks on page 1, possible risks include stinging, irritation, an unexpected reaction, contamination, and eye infection. Incorrect handling, storage, or use may increase contamination risk. Symptoms may fail to improve or may worsen, and a new blood collection or replacement preparation may be needed.

My prescribing clinician must explain the expected benefits, risks relevant to the preparation ordered and to me, reasonable alternatives, and the possible effects of choosing no treatment. Alternatives depend on my condition and may include other lubricating drops or prescribed eye treatments. I may decline eye drop services and discuss other options with that clinician.

Instructions and follow up

Before using the drops, I will obtain and follow the written instructions and product label for dose, handling, transport, storage, and discard dates. I will use the drops only for myself, will not share them, and will not use them beyond the labeled discard date. If instructions are unclear or storage has been interrupted, I will contact the dispensing team before use.

I will contact my treating eye care clinician promptly for new or worsening pain, redness, discharge, or changes in vision. Sudden vision loss or severe eye pain requires urgent medical attention. I understand that follow-up eye care remains necessary.

Patient acknowledgment and consent

I have read both pages, or had them read to me. The selected service, its risks, expected benefits, and alternatives have been explained to me. I had the opportunity to ask questions and received answers I understand. I voluntarily consent to the service selected on page 1. I understand that I may withdraw consent for future services and request a copy of this form.

Patient or authorized representative signature _____

Printed name _____ Date and time _____

If representative relationship and authority _____