PATIENT CONSENT FORM

I understand that State law guarantees my right to receive information. I hereby authorize

Dr …… and his/her associates to treat me/my relative ……..

I understand they will plan and administer cancer treatment medication(s), which are intended to control my disease, by destroying abnormal cells, reducing the risk of lesion growth or re-growth, and preventing or relieving symptoms which may be caused by the disease. These medications may include some of the following:

Sign ……

I authorize my oncology physicians and their associates to carry out the procedures necessary to give me cancer treatment, including, but not limited to: laboratory tests, diagnostic X-ray exams, tissue biopsies, and gathering and recording medical information about me.

This cancer treatment may require the need to have an intravenous (IV) line inserted into my body. This could be with a short-term type of IV placed by a nurse, or a longer-term type of catheter, placed by a physician. In addition, this treatment may require the administration of medication to minimize side effects such as allergic reactions or nausea and vomiting.

Patients receiving this treatment frequently experience side effects which may include, but are not limited to: nausea, vomiting, diarrhoea, allergic reactions, hair loss, mouth sores, fatigue, numbness and tingling of toes and fingers, and bone marrow suppression with the risk of infection, anaemia, and bleeding.

Sign……

For several weeks after the course of treatment I may be very tired; full recovery from cancer medication treatments may require several months.

In addition to the short term side effects of treatments, there might be risks of complications, which may require medical or surgical treatments, including but not limited to: organ damage, tissue injury secondary to leakage of chemotherapy under the skin and infertility.

Sign……

I have been informed of the benefits and anticipated outcomes of this proposed treatment as well as anticipated problems that may occur related to recuperation from this treatment. I

have also been informed of the benefits, risks, and consequences of alternative forms of treatment, as well as the likely results if I choose not to be treated.

I recognize that during the course of my evaluation and treatment, unexplained conditions may be discovered, which may require additional or different procedures than those mentioned above. I therefore authorize my oncology physician or nurse practitioner to evaluate and treat me in accordance with their best professional judgment.

I understand that cancer treatment medication may be harmful to human eggs or sperm and to the developing embryo or foetus.

Please sign if applicable:

I certify that I am not pregnant now and will avoid becoming pregnant or fathering children during my treatment and for six months afterward. If there is any chance that I may be pregnant or become pregnant, I will tell my oncology physician or nurse practitioner immediately.

Sign……..

I recognize that there is minimal guarantee of benefits or cure from the treatment and minimal assurance that side effects or complications of treatment will not occur. I freely consent to this treatment, knowing that I have the right to ask additional questions, refuse or withdraw
from treatment at any time without affecting my access to care.

I acknowledge that my physician or nurse practitioner and I have discussed the information set forth above and that my questions have been answered to my satisfaction.

By signing I also certify that this form has been fully explained to me, that I have read it or have had it recited to me, that the blanks have been filled in, that I understand its contents, and that I have received a copy. I make this request for treatment and grant the authority set forth above voluntarily, and assume responsibility for my decision.

_____ _____

Date Signature of Patient or Legal Guardian/witness

_____

Physician/Nurse Practitioner