

CHEMOTHERAPY CONSENT FORM

(Patient Label)

I, _____(Patient/ Next of Kin/ Legal guardian Name), Age: __Gender: __understand that I/ my patient has been diagnosed with _____ Stage _____ and will be treated with anticancer therapy potentially including biologic agents to try to reduce or possibly eliminate the cancer cells from body. This consent form provides authorization for repeat cycles of the medications listed below. I hereby consent and agree to the treatment with following anticancer therapy:

Chemotherapy Protocol:

(list all agents included in the anticancer therapy regimen)
I confirm that the treatment information has been explained to me in language I understand by doctor _____.

The treatment procedure has been explained to me as follows:

- The nature and extent of the therapy to be performed and all risk involved
- The benefits of the therapy for improvement/ Control of the condition
- The estimated period of incapacity or convalescence, if any
- The likelihood of response to chemotherapy
- The possible complications and reasonable alternatives to this treatment including having no treatment at all
- The potential benefit(s) of this therapy include but are not limited to better control of cancer, or improvement in symptoms related to cancer.
- The treatment is as per current understanding of the disease and is tailored for the individual patients.
- The possibility of the chemotherapy not being effective and/or the risk of progression of disease while on treatment.
- The substantial risks/potential side effects from this therapy may include, but are not limited to:

- | | | |
|--|--|--|
| <input type="checkbox"/> Fatigue/ Tiredness | <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Damage to Blood Vessels |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Muscle/ Joint Aches | <input type="checkbox"/> Elevated Blood Sugar |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Headache | <input type="checkbox"/> Numb Fingers or Toes/ Tingling |
| <input type="checkbox"/> Acne/ Skin Changes | <input type="checkbox"/> Low Platelet Count Which May Cause Bruising or Bleeding | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Low Blood Count Which May Result in Anemia/Infection | <input type="checkbox"/> Permanent Nerve Damage |
| <input type="checkbox"/> Eye Irritation: Blurred Vision, Skin Itching, Tearing | <input type="checkbox"/> Chills & Fever | <input type="checkbox"/> Sterility/ Infertility |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Nausea and Vomiting | <input type="checkbox"/> Abnormalities in the Liver, Kidney, Lung, Heart, Pancreas, Other Organs or Brain Function |
| <input type="checkbox"/> Weight Loss/ Weight Gain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Coma |
| <input type="checkbox"/> Facial Flushing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Secondary Cancer |
| <input type="checkbox"/> Blood in Urine, Discoloration | <input type="checkbox"/> Depression, Confusion | |
| <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Mouth Sores | |
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Allergic Reaction | |
| <input type="checkbox"/> Metallic Taste | | |

Complications Leading to Death

Other: (add additional risks if indicated): _____

- Substantial risks/side effects may be treated with medications for nausea, diarrhea, pain, high blood sugar and/ or bladder problems. The substantial risks/side effects of low blood counts may require hospitalization/ antibiotics/ other medications/ transfusion of red blood cells or platelets.

Statement of Patient/Person with Parental Responsibility for Patient:

[Please read this form carefully. Do ask if you have any further questions.

Do not sign unless you have read and thoroughly understand this form.]

- I understand that the information I have received about risks is not exhaustive and there may be other, more remote risks.
- I have received no guarantees from anyone regarding the results that may be obtained.
- I understand that some aspects or important tasks of this treatment/procedure may be performed by healthcare providers other than the primary practitioner (physician assistants, Nurses, clinical pharmacists, Jr. consultants etc.).
- I have had the opportunity to ask questions regarding the proposed treatment and all of my questions have been answered to my satisfaction and in terms I understand.
- I acknowledge that I have been given adequate time, opportunity to clarify my doubts and I understood this treatment, as stated above.

Females of Reproductive Age:

- I understand that I need to avoid becoming pregnant during my treatment.
- I am aware that the therapy may involve substantial risks/side effects to me (or my fetus, if I am pregnant) which cannot be predicted. I have been told to use effective birth control to prevent pregnancy. If I feel I may be pregnant, I will tell my doctor immediately.

Patient/Next of Kin/Legal guardian

Signature :

Name :

Date & Time :

Witness

Signature : Name :

Date & Time :

Doctor

Signature :

Name :

Date & Time :

Date & Time

