

CONSENT TO CHEMOTHERAPY

Patient Name: _____

Diagnosis: _____

Medications: _____

Possible side effects may include any of the following or a combination of the following:

- | | | |
|-------------------------|-------------------------------------|---------------------------|
| Allergic- like ractions | Skin and Nail darkening | Risk of infection |
| Anemia | Skin Ulceration at injection site | Menopausal symptoms |
| Fatigue | Skin rash | Menstrual irregularities |
| Constipation | Light Sensitivity | Sterility |
| Diarrhea | Numbness or tingling | Dizziness |
| Loss of Appetite | Hearing loss | Forgetfulness |
| Mouth Sores | Heart damage | Secondary Malignancy |
| Nausea or vomiting | Kidney damage | Muscle aching or weakness |
| Weight gain or loss | Low platelet count causing bleeding | |
| Liver damage | Low white blood cell count | |
| Hair loss | | |

Unexpected side effects may occur in addition to those noted above. Chemotherapy can be harmful to unborn child. It is important to tell the doctor if I think I may be pregnant. It is important for both men and women who are being treated with chemotherapy and who are sexually active and fertile and who have a fertile partner to use reliable form of birth control (birth control pills, a reliable barrier method, or a hormonal implant as recommended by your physician). In rare instances, cancer treatment can cause life threatening complications and death.

_____(Patient Initials) A nurse has provided and reviewed with me a written information on the drugs I will receive. **I HAVE HAD A CHANCE TO ASK ANY QUESTIONS ABOUT THE ABOVE DRUGS AND I AM SATISFIED WITH THE INFORMATION PROVIDED.**

My doctor and nurse have explained my treatment plan in detail. My doctor has also discussed with me other methods of treating this disease and the risks and benefits of treatment. There is no guarantee that this treatment will give me the same results that other patients have received. If I change my mind and decide to stop treatment at any time, my doctor will continue to provide for my care in the future.

I have read the above information and understand the possible risks and benefits of the recommended treatment plan. I agree to accept the treatment and authorize Dr. _____ and his/her designated nurse to carry out the treatment plan.

Patient Signature: _____ Date: _____ Time: _____

Patient's Legal Representative Signature: _____ Date: _____ Time: _____

Relationship: _____

Witness Signature: _____ Date: _____ Time: _____

I have explained the expected response, side effects, and possibility of risks of the listed drug to the above named patient

Physician Signature: _____ Date: _____ Time: _____

Chemotherapy Consent

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APPROVED DATE: Nursing: 3/6/13 MEC: 3/29/13 HIMC: 2/20/13

Patient ID Label