Littleton Adventist Hospital

Centura Health

Patient Bar Code ID Label

Informed Consent for Chemotherapy
Form# ON005L rev. 10/09

CONSENTDBL

PATIENT NAME: _____

DIAGNOSIS/CONDITION: _____

DATE(S) OF TREATMENT: _____

I hereby authorize _____ (practitioner) and/or such assistants as may be selected by him/her to administer the following chemotherapy medications to treat my disease: _____

_____

_____

RISKS OF PROPOSED TREATMENT

_____ (Practitioner) has discussed with me the above medications, the anticipated benefits, material risks, and alternative therapies. This authorization is given with the understanding that any treatment/procedure and recuperation involves some risks and hazards. The more common risks include:

Mild Effects:
- ☐ Visual changes
- ☐ Blurred vision, itching, tearing
- ☐ Weight loss
- ☐ Weight gain
- ☐ Temporary hair loss
- ☐ Skin rash
- ☐ Acne
- ☐ Fatigue
- ☐ IV site discomfort
- ☐ Darkening of skin/nails
- ☐ Facial flushing
- ☐ Appetite change
- ☐ Urine discoloration
- ☐ Menstrual Irregularities
- ☐ Hot flashes
- ☐ Metallic taste
- ☐ Nasal congestion
- ☐ Muscle/joint aches
- ☐ Confusion
- ☐ Other: _____

Moderate Effects:
- ☐ Bruising/bleeding
- ☐ Blood in urine
- ☐ Weakness
- ☐ Anemia/Shortness of breath
- ☐ Chills
- ☐ Fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Depression
- ☐ Mouth sores
- ☐ Skin/eye light sensitivity
- ☐ Allergic-like reactions
- ☐ Bladder irritation

Severe Effects:
- ☐ Hearing loss
- ☐ Skin ulceration
- ☐ Numbness/tingling
- ☐ Sterility
- ☐ Infection
- ☐ Lung damage
- ☐ Heart damage
- ☐ Liver damage
- ☐ Kidney damage
- ☐ Brain damage
- ☐ Secondary cancers
- ☐ Death

ASSISTANTS

I understand that some aspects or important tasks of this treatment/procedure may be performed by healthcare providers other than the primary practitioner (i.e., physician assistants, advanced practice nurses, registered nurses, etc.). I understand that the care provided by these practitioners will be within the scope of their practice or privileges granted and will be performed in accordance with the state law and the hospital's policies.

ALTERNATIVE THERAPIES
The following therapies are available to treat my cancer: (please list)

The advantages, disadvantages, and benefits of all alternative therapies have been explained to me and I agree to receive the particular chemotherapy offered to me based on this information.

_____ Date: _____ Time:_____
Signature of physician or licensed independent practitioner or physician assistant who conducted the informed consent discussion.

PATIENT CONSENT
My doctor has fully explained the chemotherapy treatment in words I understand, and I understand that no guarantees have been made to me regarding the results of this treatment and that it may or may not improve my condition. I have had sufficient opportunity to discuss my condition and treatment with my physicians and/or their associates, and all of my questions have been answered to my satisfaction. I believe that I have been given sufficient information and adequate knowledge upon which to make an informed decision about undergoing the proposed treatment. I have been informed of alternatives to this treatment and the risks of the alternatives. I have read and fully understand this form and I voluntarily authorize and consent to this treatment.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

_____ Date: _____ Time:_____
Signature of patient or legal guardian