Littleton Adventist Hospital

Centura Health

Patient Bar Code ID Label

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



CONSENTORI

PATIENT NAME:		
DIAGNOSIS/CONDITION:		
DATE(S) OF TREATMENT:		
	(practitioner) and/or such a hemotherapy medications to treat my dis	
	(Practitioner) has discussed with me the	· · · · · · · · · · · · · · · · · · ·
	ve therapies. This authorization is given wan involves some risks and hazards. The r	
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	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 Stidney damage Brain damage Secondary cancers Death

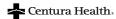
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ASSISTANTS

☐ Confusion☐ Other: _____

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.

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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.

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D	ate:	Time:
Signature of physician or licensed independent practitioner or physician		

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			