Consent to Systemic Anti-Cancer Therapy

This form must not be used for patients who lack mental capacity (use Trust Consent form 4)

Name of proposed treatment ……………………………………………………………………………..

Proposed number of cycles/ duration …………………………………………………………………..

Statement by health professional (to be filled in by a health professional with an appropriate knowledge of the proposed treatment, as specified in the consent policy)

I have explained the treatment, what it is likely to involve, its benefits and risks together with those of any available alternative treatments (including no treatment). In particular, I have explained:

• that the aim of the procedure is
  □ Curative – to give the best possible chance of being cured
  □ Non-Curative – the aim is to control or shrink the disease especially if it is causing specific symptoms, to try and keep you as well as possible for as long as possible but not cure you

• the serious or frequently occurring risks of the treatment. These are detailed in the information leaflets provided (see below) and include (tick those that may apply)

  □ anaemia  □ fatigue/ tiredness  □ lung effects  □ risk of infection
  □ blood clots  □ heart effects  □ nausea and vomiting  □ skin effects / hair loss
  □ constipation  □ kidney or bladder effects  □ nerve damage  □ sore mouth or throat
  □ diarrhoea  □ local damage to tissues  □ risk of bleeding  □ subfertility
  □ need for blood transfusion  □ late effects ………………………

Subject Number/ Source patient to initial______

Subject Number/ Source patient to initial______

Subject Number/ Source patient to initial______

Colney Centre Filofax patient to initial______

Health Professional’s signature: ……………………… Date: ………………………

Name (PRINT): ………………………………………… Job Title: …………………………………………

Statement of interpreter (where appropriate)

I have interpreted the information on this form to the patient/parent to the best of my ability and in a way in which I believe s/he can understand.

Interpreter’s signature: …………………… Name (PRINT): …………………… Date: ………
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Statement of patient/person with parental responsibility for patient

Please read this form carefully. Do ask if you have any further questions. You have the right to change your mind at any time, including after you have signed this form. Please initial the boxes and sign.

☐ I understand that there are benefits of this treatment if it is successful. I also understand that my doctors cannot be sure that the treatment will help me.

☐ I understand that this treatment can have short term and long term side effects. The serious and frequently occurring ones are detailed in the information leaflets I have been given and stated on the first page of consent form.

☐ I understand that I could have side effects from my treatment that are not listed on this form. Each patient can respond differently to chemotherapy, and could have side effects that have not been reported by others.

☐ I have had the chance to ask questions about this treatment and my questions have been answered to my satisfaction.

☐ I understand that I may stop this treatment at any time.

☐ I understand that by signing this form I am consenting to receive the treatment recommended by my doctor and described on this form.

☐ I understand that I may need blood products as part of my treatment and consent*/do not consent* to receiving them (delete as appropriate)

☐ I give permission for data held in my medical records to be used for research purposes. Any such research will be approved by a research ethical committee would be anonymous and undertaken in accordance with appropriate ethical, legal and professional standards.

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Females of reproductive age:

☐ I confirm that I am not pregnant

☐ I understand that I need to avoid becoming pregnant during my treatment

☐ I will inform the staff treating me as soon as I can, if I think at any stage that I might be pregnant

Males:

☐ I understand that I should not father children while I am receiving my treatment as there may be unknown effects on my sperm.

☐ I have declined*/requested* sperm cryopreservation (* delete as appropriate)

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Signature of patient or Patient representative (PR): ………………………………Date:  …………………..

Name: (PRINT). ……………………………Relationship to patient if PR Signing:  ………………………..

Written consent will be taken in advance of chemotherapy but verbal consent will be confirmed with you at each attendance for treatment.

Copy accepted by patient: ☐ Yes ☐ No (please tick)