Consent to Systemic Cancer Treatment

Affix patient identification label in this box

UR Number: .....

Surname: .....

Given name: .....

Second given name: .....

D.O.B: __ __ / __ __ / __ __ __ __ Sex: .....

I, _____ , DOB ___ / ___ / ___ , URN _____

Acknowledge and understand that I have been diagnosed with _____.

I consent to undergo the following course of:

Chemotherapy / Immunotherapy / Molecular Targeted Therapy / Hormonal Therapy. (circle all that apply)

Proposed Treatment:	**Route of administration:** ☐ oral ☐ intravenous ☐ subcutaneous ☐ other: _____
Total duration of the full course:	
Length of each "cycle":	

☐ The above treatment will overlap with radiotherapy

☐ The treatment options have been explained to me in detail by _____

☐ The goal of my treatment has been discussed.

☐ The treatment will be dispensed and/or administered by qualified health professionals at (name of hospital):

_____

☐ The reasonable alternatives to this treatment have been explained to me, including:

_____

☐ I acknowledge the nature, consequences and potential risks have been explained to me.

☐ I understand that the treatment may have side-effects that are potentially serious and rarely could cause my death.

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

☐ I will receive a copy of this consent form.

☐ I understand that by signing this document I am consenting to receive the cancer medicines proposed by my health care provider as detailed above.

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

☐ I have read and understood the following information sheets (e.g. EviQ) which explain the treatment and risks involved: _____

* Please contact your medical team for advice regarding how to manage any side effects of treatment.
* Support is available 24 hours a day through your treating hospital switch board.

POTENTIAL RISKS AND SIDE EFFECTS OF TREATMENT

Treatment may cause bone marrow suppression leading to low counts of red blood cells (anaemia) and other bloods cells that may lead to:

- ☐ fever / serious infection
- ☐ bleeding
- ☐ tiredness

Treatment may also directly or indirectly lead to symptoms of:

- ☐ hair loss
- ☐ nausea / vomiting
- ☐ altered taste
- ☐ mouth ulcers
- ☐ constipation
- ☐ diarrhoea
- ☐ skin problems
- ☐ kidney problems
- ☐ heart problems
- ☐ lung problems
- ☐ liver problems
- ☐ sexual problems
- ☐ reproductive / fertility problems
- ☐ nervous system problems
- ☐ other: _____
- ☐ all of the above

Please seek immediate medical attention by attending the closest hospital emergency department if you develop a fever above or equal to 38°C

Immunotherapy may lead to inflammation of organs, including:

- ☐ liver
- ☐ stomach or intestines
- ☐ lungs
- ☐ hormone producing glands
- ☐ nervous system
- ☐ kidneys

Rarer areas of inflammation include:

- ☐ joints, muscles
- ☐ pancreas
- ☐ heart
- ☐ any part of the body

Immune therapy may directly or indirectly lead to symptoms including (but not limited to):

- ☐ skin rash
- ☐ diarrhoea, mucus or blood in the stools
- ☐ breathlessness and cough
- ☐ nausea / vomiting
- ☐ abdominal pain
- ☐ muscle weakness
- ☐ numbness / tingling in the hands / feet
- ☐ eyes (causing blurred vision / pain)
- ☐ abnormal liver function tests / jaundice
- ☐ other: _____
- ☐ all of the above

The mechanism and severity of these symptoms are different from those of chemotherapy.

If you are on immunotherapy, please seek immediate medical attention by attending the closest hospital emergency department if you develop diarrhoea or progressive shortness of breath.

General risks include:

- ☐ tiredness and feeling weak (fatigue) / loss of appetite
- ☐ infusion-related reactions (such as a high temperature, chills, shivering (rigors)
- ☐ pain at the site of the infusion
- ☐ flu-like symptoms
- ☐ problems with sleep
- ☐ risk of secondary cancer
- ☐ other (specify): _____
- ☐ all of the above

Interpreter Declaration – I _____ have given a verbal translation of this form relating to consent for systemic cancer therapy in a language the patient understands which is _____.

Interpreter's signature: _____ *Interpreting service:* _____ *Date* ___ / ___ / ___

Consent by a third party – If consent to systemic cancer therapy is required by a third party, then SA Health *MR82B Consent To Medical Treatment By A Third Party* must be completed.

☐ I understand and acknowledge that this consent is valid only for full course of treatment planned.
☐ I also understand that I may stop this treatment at any time.

Patient Name	Signature	DATE	Doctor Name	Signature	DATE