Hospital Logo

PATIENT CONSENT FORM FOR

SYSTEMIC THERAPY[1]

Other Logo (e.g. HSE)

To be completed by hospital and signed by patient following discussion with patient prior to treatment.

Hospital Name:	
Hospital Number:	
Treating Consultant's Name:	
Consultant registration number:	

Patient identifier / label

PATIENT CONSENT FOR SYSTEMIC THERAPY

I, _____*(patient's name)*_____, understand that I have been diagnosed with _____

_____*(type of cancer)*_____

I understand that the treatment suggested by my doctor, Prof. / Dr. *(delete as appropriate)*____*(name of treating consultant)*_____, will involve *(list drugs/regimen)*

_____

_____

I understand that there are benefits of this treatment if it is successful. Although the therapy is anticipated to be beneficial to me, its goals may not be achieved and may not be of benefit.

I understand that the medications recommended can have short-term and long-term side effects. My doctor talked to me about the following side effects that I might experience because of my treatment: *(tick all that apply; additional space provided for physician comments)*

☐ Nausea / vomiting	_____	☐ Skin effects	_____
☐ Hair loss	_____	☐ Muscle / bone effects	_____
☐ Low red blood cell count / anemia	_____	☐ Nerve effects	_____
☐ Fatigue	_____	☐ Kidney / bladder effects	_____
☐ Risk of infection	_____	☐ Sexual effects	_____
☐ Risk of bleeding	_____	☐ Heart effects	_____
☐ Constipation	_____	☐ Lung effects	_____
☐ Diarrhoea	_____	☐ Reproductive / fertility effects	_____
☐ Sores of the mouth and throat			

☐ Other _____

_____

_____

_____

I understand that I could have side effects from my treatment that are not listed on this form. Each patient can respond differently to treatment and could have side effects that have not been reported by others. I understand that complications from my treatment may arise and, in rare circumstances, could cause my death.

[1] Systemic therapy includes chemotherapy, biological therapy, targeted therapies and hormonal therapy for malignant disease.

Patient identifier / label

The purpose of this therapy has been explained to me and I understand the treatment is being given in the hope of: *(tick as appropriate)*

- ☐ Preventing a recurrence of my malignancy, with there currently being no definite evidence of tumour being present (adjuvant treatment).
- ☐ Causing complete disappearance, partial disappearance, or stabilization of the malignancy prior to completing surgery (neo-adjuvant treatment).
- ☐ Causing complete disappearance, partial disappearance, or stabilization of the malignancy to prolong my life and/or alleviate the symptoms associated with my malignancy.

My doctor(s) may stop my treatment if it is determined that the therapy has been of no benefit to me or that the risks of continued treatment outweigh its benefits. I also understand that I may stop this treatment at any time.

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

_____*(insert details of reasonable alternatives, as appropriate)*_____

I have had the chance to ask questions about this treatment and my questions have been answered to my satisfaction. I understand that I can contact my healthcare provider at any time if I have questions by contacting

(hospital should pre-print relevant contact details here)

I understand that by signing this document I am consenting to receive treatment as proposed by my health care provider.

PATIENT'S SIGNATURE For consent to treatment as above.

Patient's signature Date: D D - M M - Y Y Y Y

Patient printed name:

PHYSICIAN'S SIGNATURE:

Physician's signature: Date: D D - M M - Y Y Y Y

Physician's printed name:

Physician's Job Title / Grade:

Physician's Medical Council Registration Number:

Consent forms to be held on file by hospitals in line with local practice