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**INSTITUTION NAME**

INSTITUTION ADDRESS

**CONSENT FOR ORAL CHEMOTHERAPY**

**FOR INPATIENTS:** AFFIX PATIENT LABEL **OR**

WRITE IN BOTH PATIENT NAME & MR NUMBER

**FOR OUTPATIENTS:** WRITE IN BOTH PT NAME & DOB

PATIENT NAME: DOB OR MR #:

1. I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient name / legal guardian for patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_), do consent to the prescription or oral chemotherapy (oral cancer treatment) by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or his/her designee.

I have been diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. My physician has recommended an oral chemotherapy for this condition. The intent for treatment is \_\_\_\_ curative or \_\_\_ palliative. My oral chemotherapy involves the use of the following drug(s), with the indicated duration of treatment: \_\_\_\_ cycles, or \_\_\_\_ until disease progression or intolerance:

1. I understand that I will be taking a pill to treat my cancer.
2. I understand that the level of my response to the treatment and the time that I will be free of cancer cannot be guaranteed. I understand that I may refuse to receive treatment or stop the oral chemotherapy at any time.
3. My provider has reviewed, and I understand there are side effects that could be related to cancer treatment. Common side effects include but are not limited to the following list. I agree to tell my provider if I have any of these side effects:

(Pt. Initials)

* fever, which may be caused by low blood counts or infection
* bleeding or easy bruising
* nausea, vomiting, or loss of the need or want to eat
* stomach upset or acid reflux
* hair thinning and other hair changes
* mouth or throat sores; taste changes
* skin changes: rash or skin peeling on hands or feet
* change in eyesight
* more sensitive to sun
* burning with urination, or blood (red or pink color) in the urine
* diarrhea (frequent stools) or constipation (no bowel movement)
* change to the nails or nailbeds
* headaches, blurred vision, feeling dizzy, or loss of muscle control
* numbness and tingling of fingers and toes
* change in menstrual cycle
* weight gain or loss
* feeling tired
* hard to breathe; new or worse cough
* swelling, pain, or redness in either the arm or leg
* rise in blood pressure

1. My provider has discussed with me and I understand that treatment may have other serious problems. Serious problems may include, but are not limited to:

* injury to liver, kidney, heart, bladder or lung
* secondary cancer
* sterility
* death

(Continued on Reverse Side)

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**FOR OUTPATIENTS:** WRITE IN BOTH PT NAME & DOB

PATIENT NAME:

DOB OR MR #:

1. I understand that my provider(s) will follow me closely to check for and manage side effects. I understand that the timing of side effects cannot always be predicted.
2. I understand that blood tests and scans will be done on a regular basis. This will check my body’s response to treatment and the cancer.
3. I have been provided with written and verbal information about the oral cancer treatment I will receive. Specifically:

* I know the name of the chemotherapy.
* I understand how and when to take the drug.
* I understand that I cannot tamper with the pill in any way and that I must take it as directed.
* I know what foods or other medications to avoid while taking this treatment.
* I understand how to store this drug and understand how important it is to keep this drug away from children and pets.
* I know what to do if I miss a dose.
* I understand how to protect others from exposure to my body fluid waste (urine, stool, vomit, semen, or vaginal secretions) and this cancer treatment.
* I understand how to manage common side effects, how to report side effects, and who to call should I have any further questions

1. I know that it is important to take my oral cancer therapy as prescribed and that missing doses could lower the chance of a response to treatment.
2. This form was explained to me and I understand its contents. I have been given a chance to ask questions and all of my questions have been answered.

Signature:

(Patient or Legal Guardian)

Relationship:

Date:

Time:

A.M./P.M

# Provider’s Acknowledgement:

I confirm that consent, as described above, has been given by this patient (or Legal Guardian).

Print Name: Signature:

(Provider) (Provider)

Date:

Time:

A.M./P.M

# Interpreter’s Acknowledgement (if applicable):

I confirm that consent as described above, has been given by this patient (or Legal Guardian).

Print Name: Signature:

(Interpreter) (Interpreter)

Date:

Time:

A.M./P.M