CANCER TREATMENT INFORMEDCONSENT/ASSENT FORM

MINISTRY OF HEALTH

Informed Consent/Assent to Cancer Treatment

Name of Cancer Management Centre_____

Date: _____

Patient Details:

Name _____

Age (Years) _____

Gender _____

Name of translator (if applicable)_____

Name of parent/guardian (for children) _____

Place of consent_____

I understand that I (or my child) have been diagnosed with

_____

I understand that the treatment suggested by my healthcare team led by Dr. (Name of oncologist) _____, will involve (tick all that apply)

- ☐ Chemotherapy
- ☐ Radiotherapy
- ☐ Radio-ablative therapy
- ☐ Surgery
- ☐ Others (Specify) _____

The aim of my/my child's treatment is

- ☐ Cure
- ☐ Relief of symptoms
- ☐ Reduction of tumour size
- ☐ Maintenance therapy
- ☐ Others (Specify) _____

Further, I understand that:

1. I am an adult of sound mind capable of making decisions on my behalf (or my child)
2. Other health care providers may be needed for my care
3. There are benefits of this treatment if it is successful
4. My healthcare team cannot guarantee that the treatment aim will be achieved.
5. The treatment recommended by my healthcare team can have short-term and long-term adverse effects. I have been informed about the side effects that I might experience because of my treatment
6. The reasonable alternatives to this treatment have been explained to me

7. Upon review, my healthcare team may recommend a change or termination of my treatment

8. I can voluntarily opt out of the suggested treatment option at any time without any prejudice.

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

10. I can contact my health care team at any time if I have questions, by calling this phone number_____
11. I am signing this consent without any coercion or under duress.

12. I will receive a copy of this consent form and by signing this document I am consenting to receive the treatment proposed by my health care provider.

Patient/Guardian Name_____

Patient/Guardian Signature _____

Date_____

Healthcare Provider Signature_____ Date_____

Witnesses

1. Patient's Witness: Name _____Signature _____

   Date_____

2. Healthcare worker: Witness Name _____Signature _____

   Date_____

3. Child Assent (for children >7 years): Name _____

   Signature/Thumb print _____ Date _____