Garnet Health
MEDICAL CENTER

Carmona, Robert A
Sex:M DOB:6/22/1971 49 y.o.
MRN:667252 DOS:7/28/20
Acct: 5001646021
OSN: 13923970

**Informed Consent for Infusion Center Treatment**

I hereby give my consent and authorize: Dr. Cabos - Vargas and those who he/she may designate as associates or assistants and Garnet Health Medical Center (Hospital) and its staff to perform the following

treatment upon: Carmona Robert
(Patient's name).

(Describe the treatment in both clinical and laymen's terms. No Acronyms or Abbreviations):

Medication Administration - Cimzia injection:
Lab draws -

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the treatment may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with the, use of medication, and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the treatment(s) specified above.

7/28/20 AM PM — Robert Carmona — _____ — _____
(Date) (Time) (Patient/Health Care Agend/Surrogate/Guardian Signature) (Printed Name) (Relationship to Patient)

7/28/20 AM PM — [signature] — Pavlovich
(Date) (Time) (Witness Signature) (Printed Name)

☐ Mark this box if interpreter was involved. _____ (Interpreter ID #)

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the treatment(s), the alternatives, including not performing the treatment(s), as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

[signature]
(Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation)

Garnet Health
MEDICAL CENTER

Carmona, Robert A
Sex:M DOB:6/22/1971 49 y.o.
MRN:667252 DOS:7/28/20
Acct: 5001646021
CSN: 13923970

# CHEMOTHERAPY INFORMED CONSENT

I hereby authorize Dr. Cabas-Vargas, and or associates or assistants of his/her choice, to administer to me the following chemotherapy consisting of the following drugs.

1. Cimzia injechons.
2. _____
3. _____
4. _____
5. _____
6. _____

I have been fully informed of my diagnosis, nature and purpose of the chemotherapy infusion. The potential benefits and drawbacks including the impact on daily activities related to recuperation have been discussed. The complications, likelihood of success, discomforts and possible risks that may arise have been addressed. The alternatives, including possible results of non treatment have been reviewed with me. I acknowledge that no guarantees or assurances have been given to me about the chemotherapy infusion. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of this chemotherapy, unforeseen conditions may arise which could require the planned chemotherapy to be altered. All alterations of the proposed plan will be discussed with me by my physician.

I understand that the medications prescribed by my physician can have short term and long term side effects. My physician has educated me about the following side effects that I might experience because of my chemotherapy.

- ☐ Nausea / Vomiting
- ☐ Anemia / Low Red Blood Cells
- ☒ Risk of Infection
- ☐ Poor Appetite
- ☒ Rash
- ☐ Numbness/tingling
- ☐ Hair Loss/thinning
- ☒ Fatigue
- ☐ Mouth Sores
- ☐ Diarrhea/Constipation
- ☒ Bleeding/low platelet counts
- ☐ Other

I also understand that I may stop treatment at any time.

Patient/Relative Signature: Robert Carmona Date: 7/28/20

Relationship, if not patient: _____ Date: _____

Physician Signature: _____ Date: 7/28/2020

Witness to Patient Signature: _____ Date 7/28/20

Garnet Health
MEDICAL CENTER

# Fax

To: Garnet Health Doctors: RHEUMATOLOGY Fax: (845) 333 7201

From: Outpatient Infusion Center

Phone : (845) 333 1150

Infusion inbound fax: (845) 333 9400

Date: Total Pages (including cover):

Subject:

Notes:

Garnet Health
MEDICAL CENTER

Castaldo, Francina D
Sex:F DOB:10/13/1939 80 y.o.
MRN:22360 DOS:7/28/20
Acct: 5001643685
CSN: 13887788

**Informed Consent for Infusion Center Treatment**

I hereby give my consent and authorize: Dr. Hadlis and those who he/she may designate as associates or assistants and Garnet Health Medical Center (Hospital) and its staff to perform the following treatment upon: Francina Castaldo (Patient's name).

(Describe the treatment in both clinical and laymen's terms. No Acronyms or Abbreviations):

Zebo drug, Medication administration

I give permission with full knowledge and understanding thereof. I understand that medicine is not an exact science and that there is the possibility that the treatment may not have the benefits or results intended. I am also aware that there are always risks and dangers to life and health associated generally with the, use of medication, and treatments which can cause adverse consequences not ordinarily anticipated in advance, but I give this permission with full assent nevertheless.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the treatment(s) specified above.

7/28/2020 11:33 AM/PM — (Date) (Time) — Francina Castaldo — FRANCINA CASTALDO — (Patient/Health Care Agent/Surrogate/Guardian Signature) (Printed Name) (Relationship to Patient)

7/28/2020 11:33 AM/PM — (Date) (Time) — (Witness Signature) — ROSALINDA YAP — (Printed Name)

☐ Mark this box if interpreter was involved. _____ (Interpreter ID #)

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the treatment(s), the alternatives, including not performing the treatment(s), as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

(Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation)

Garnet Health
MEDICAL CENTER

Castaldo, Francina D
Sex:F DOB:10/13/1939 80 y.o.
MRN:22360 DOS:7/28/20
Acct: 5001643685
CSN: 13887788

# CHEMOTHERAPY INFORMED CONSENT

I hereby authorize Dr. Fradis, and or associates or assistants of his/her choice, to administer to me the following chemotherapy consisting of the following drugs.

1. Cisplatin
2. _____
3. _____
4. _____
5. _____
6. _____

I have been fully informed of my diagnosis, nature and purpose of the chemotherapy infusion. The potential benefits and drawbacks including the impact on daily activities related to recuperation have been discussed. The complications, likelihood of success, discomforts and possible risks that may arise have been addressed. The alternatives, including possible results of non treatment have been reviewed with me. I acknowledge that no guarantees or assurances have been given to me about the chemotherapy infusion. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during the course of this chemotherapy, unforeseen conditions may arise which could require the planned chemotherapy to be altered. All alterations of the proposed plan will be discussed with me by my physician.

I understand that the medications prescribed by my physician can have short term and long term side effects. My physician has educated me about the following side effects that I might experience because of my chemotherapy.

- ☐ Nausea / Vomiting
- ☑ Anemia / Low Red Blood Cells
- ☑ Risk of Infection
- ☐ Poor Appetite
- ☑ Rash
- ☐ Numbness/tingling
- ☐ Hair Loss/thinning
- ☑ Fatigue
- ☐ Mouth Sores
- ☐ Diarrhea/Constipation
- ☑ Bleeding/low platelet counts
- ☐ Other

I also understand that I may stop treatment at any time.

Patient/Relative Signature: Francina Castaldo Date: 7/28/2020

Relationship, if not patient: _____ Date: _____

Physician Signature: _____ Date: 7/29/20

Witness to Patient Signature: _____ Date 7/28/2020

Garnet Health
MEDICAL CENTER

# Fax Dr. Fradkin

To: Garnet Health Doctors: RHEUMATOLOGY Fax: (845) 333 7201

From: Outpatient Infusion Center

Phone : (845) 333 1150

Infusion inbound fax: (845) 333 9400

Date: 7/28/2020 1214 Total Pages (including cover): 3

Subject:

Notes: Pls sign consents for F. Castaldo (10/13/39)
Fax back

Pls let Dr. Fradkin know that
pt refused blood works done @
Dr Strohm's office

Thank you

*This transmission is intended only for the individual to whom it is addressed, and may contain a patient's protected health information ("PHI") or other confidential information. If you are not the intended recipient, or the person responsible for delivering this transmission to the intended recipient, please (a) notify the sender immediately by telephone, and (b) shred or otherwise destroy this transmission immediately afterward. Thank you.*