Garnet Health
MEDICAL CENTER

Carmona, Robert A
Sex:M DOB:6/22/1971 49 y.o.
MRN:667282 DOS:7/28/20
Acct: 5001646021
CSN: 13823970

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 injections.
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: [signature] Date: 7/28/2020

Witness to Patient Signature: [signature] Date: 7/28/20

Garnet Health
MEDICAL CENTER

Carmona, Robert A
Sex:M DOB:6/22/1971 49 y.o.
MRN:667252 DOS:7/28/20
Acct: 9001648021
CSN: 13923979

Informed Consent for Infusion Center Treatment

I hereby give my consent and authorize: Dr. Cabo - 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 Agent/Surrogate/Guardian Signature)	(Printed Name)	(Relationship to Patient)
7/28/20	AM/PM	[signature]	Pamlovich	
(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)

Risk Management/nam/March 2016

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:

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