ORANGE REGIONAL MEDICAL CENTER

FAX TRANSMISSION

Date:	Time:	From:
2/6/20	0940	

Dr. Stead/Dr. Koulova

Fax #: 845-294-1669

Cancer Center
Outpatient Infusion Center

Phone: 845-333-1150

Infusion InBound Fax: 845-333-9400

Number of pages, including this coversheet: 6

Information Transmitted:

Please sign consents, labs for your review

Thank you.

ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Infusion Center Treatment

McCord, Gilbert K
Sex:M DOB:6/30/1965 54 y.o.
MRN:188256 DOS:2/06/20
Acct: 5081840405
CSN: 12833947

I hereby give my consent and authorize: Dr. Koulova and those who he/she may designate as associates or assistants and Orange Regional Medical Center (Hospital) and its staff to perform the following treatment upon: Gilbert McCord
(Patient's name).

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

Mediport access, lab draw, 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.

(Date)	(Time)	(Patient/Health Care Agent/Surrogate/Guardian Signature)	(Printed Name)	(Relationship to Patient)
2/6/2020	AM	x Gilbert K McCord	x Gilbert K McCord	
2/6/2020	AM	Witness Signature	Witness 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)

FAXED 2/6/20

ORANGE REGIONAL MEDICAL CENTER

McCord, Gilbert K
Sex:M DOB:6/30/1966 54 y.o.
MRN:185258 DOS:2/06/20
Acct: 5001840486
CSN: 12933947

CHEMOTHERAPY INFORMED CONSENT

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

1. Oxaliplatin
2. Leucovorin
3. 5 fluoral
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.

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

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

Patient/Relative Signature: Gilbert McCord Date: 2/6/2020 0845

Relationship, if not patient: _____ Date: _____

Physician Signature: [signature] Date: 2/10/20

Witness to Patient Signature: MDecker Date: 2/6/2020 0845

FAXED 2/6/20

ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Infusion Center Treatment

McCord, Gilbert K
Sex:M DOB:6/30/1955 64 y.o.
MRN:185256 DOS:1/15/20
Acct: 5001524753
CSN: 12923223

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

treatment upon: GILBERT K McCord
(Patient's name).

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

IV insertion lab draws, IV medications

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.

1/15/20 (Date) ____ (Time) AM PM [signature] (Patient/Health Care Agent/Surrogate/Guardian Signature) Gilbert McCord (Printed Name) ____ (Relationship to Patient)

1/15/20 (Date) ____ (Time) AM PM [signature] (Witness Signature) M. Beltran (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)

FAXED 1/15/20

MCCORD, GIL K (MRN 185256)

	1
	2/6/2020 0843
AUTOMATED HEMATOLOGY	
WBC	3.0 ▼
RBC	3.56 ▼
HEMOGLOBIN	11.2 ▼
Hematocrit	35.5 ▼
MCV	99.7 ▲
MCH	31.5
MCHC	31.6
RDW	13.2
Platelets	209
Abs Neutrophil Count	1,941
Neutrophils Relative	64.7
Lymphocytes Relative	17.2
Monocytes Relative	15.0 ▲
Eosinophils Relative	2.0
Basophils Relative	0.3
IG Relative	0.8
Neutrophils Absolute	2.0
Lymphocytes Absolute	0.5 ▼
Monocytes Absolute	0.5
Eosinophils Absolute	0.06
Basophils Absolute	0.0
COAGULATION	
Prolime	
INR	
GENERAL CHEMISTRY	
Sodium	140
Potassium	3.8
Chloride	107
CO2	26
BUN	8
Glucose	184
CALCIUM	8.3
Creatinine, Ser	0.73
Total Bilirubin	0.5
ALBUMIN	3.7
Total Protein	6.1 ▼
Alkaline Phosphatase	66
AST	28
ALT	39
Anion Gap	7 ▼
eGFR AFRICAN AMERICAN	>60.0
eGFR NON AFRICAN A...	>60.0
Magnesium	1.6
IR IMAGING	
SP CATH PLACEMENT ...	
SP US GUIDED VAS A...	
ECHO	
ECHOCARDIOGRAM 2D ...	