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):

labs draws, 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)
7/28/2020	1133 AM/PM	Francina Castaldo	FRANCINA CASTALDO	
7/28/2020	1133 AM/PM			

(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 of Physician/Appropriately Credentialed Practitioner Providing Explanation)

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CHEMOTHERAPY INFORMED CONSENT

I hereby authorize Dr. Gadkis, 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)
4 pages back

Pls let Dr. Fradkin know that
for repeat blood works done @
Dr Stokis office

Thank you