

## FAX TRANSMISSION

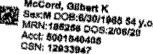
Pate: 2/6/20	0940	From:
Dr. Stead/Dr. Koulova Fax #: 845-294-1669		Cancer Center Outpatient Infusion Center Phone: 845-333-1150 Infusion InBound Fax: 845-333-9400
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Information Transmitted: Puwe 80	n consent	, labs for your review
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he documents accompanying this transmission co- infended only for he use of the individuals or entity formation to any other party and is required to dea ou are hereby notified that any disclosure, copying, ou have received this fex in error please notify us in	ntain cynlidential informets y named above. The autho troy the information after it distribution or action takes nonediately at the telephon	on belonging to the sender, which is legally privileged. This information which extremely of the information is prohibited from disclosing the stated need has been fulfilled. If you are not the intended recipient, in in reliance on the coments of these documents is strictly prohibited. If a number atlove. Thank You.
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I hereby give my consent and authorisassociates or assistants and Orange R treatment upon:	egional Med	2ºC&id	and its staff to perfi	ss who he/she may corm the following	TOS GUELLE ES		
(Describe the treatment in both clinic		*.	yms or Abbreviation	·s):			
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I give permission with full knowledge there is the possibility that the treatme risks and dangers to life and health as consequences not ordinarily anticipate	ocieted ver	have the benefits of a terally with the use o	esults intended. I am Emedication, and em	siso aware that the:			
By signing below, I confirm that I ful- give my consent to the treatment(s) sp	y understan ecified abov	d the information prove.	vided to me, my ques	nions have been ans	Werod, and I		
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Signature of Physician/Appropriately	Credentiale:	d Practitioner Provid	ng Explanation)	Fi	HARED MARIE		

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Risk Management/nem/March 2016

Page 1 of 1



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I have been fully informed of my diagnost drawbacks including the impact on daily act success, discomforts and possible risks that treatment have been reviewed with me, I a chemotherapy infusion. I have been given the and satisfactority.	vities related to recuperat may arise have been add dknowledge that no gual	ion have been discussed. The co ressed. The alternatives, includin antees or assurances have been	mplications, likelihood of g possible results of non a given to me about the
I understand that during the course of this chemotherapy to be altered. All attentions of	The proposed plan will b	discussed with me by my physic	an.
I understand that the medications prescribed educated me about the following side effects	by my physicien can hay that i might experience b	e short term and long term side e occuse of my chemotherapy.	ffects. My physician has
Nausea / Vomiting Anemia / Low Red Blood Cells Risk of Infection Poor Appetite Rash Humbness/tingling	Fallique Moudh Diarrin		,
I also understand that I may stop treatment a	town 1	Date: 2/6/202	o sevic
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Physician Signature: 100 Witness to Patient Signature: 100	cher o	ate 2/6/2020	0845
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Form/TCCC/Chemotherapy Informed Consent/EE-am/6/10

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