ORMC ORANGE REGIONAL MEDICAL CENTER

FAX TRANSMISSION

Date: 1/4/2010	Time: 1710	From:
Dr. Stead/Dr. Koulova Fax #: 845-294-1669		Cancer Center Outpatient Infusion Center Phone: 845-333-1150 Infusion InBound Fax: 845-333-0400

Number of pages, including this coversheet: 3

Information Transmitted:

Pls Sign Consent of A Ricciardi Jr (11/4/67) & fax back

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ORANGE REGIONAL MEDICAL CENTER

Informed Consent for Infusion Center Treatment

Ricciardi, Anthony Jr.
Sex:M DOB:11/11/1967 52 y.o.
MRN:386740 DOS:1/28/20
Acct: 5001312948
CSN: 12976481

I hereby give my consent and authorize: Dr. Stead 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: Ricciardi Anthony
(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.

1/28/20 AM PM — (Date) (Time) — (Patient/Health Care Agent/Surrogate/Guardian Signature) — Anthony Ricciardi — (Printed Name) — Self — (Relationship to Patient)

1/28/20 AM PM — (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.

Lesley A. Stead, MD
(Signature of Physician/Appropriately Credentialed Practitioner Providing Explanation)

FAXED 1/28/20 5:11 pm

ORANGE REGIONAL MEDICAL CENTER

PATIENT

CHEMOTHERAPY INFORMED CONSENT

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

1. Docetaxel
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.

- [x] Nausea / Vomiting
- [x] Anemia / Low Red Blood Cells
- [x] Risk of Infection
- [x] Poor Appetite
- [x] Rash
- [x] Numbness/tingling
- [x] Hair Loss/thinning
- [x] Fatigue
- [x] Mouth Sores
- [x] Diarrhea/Constipation
- [x] Bleeding/low platelet counts
- [x] Other List of additional S/E +S/S provided from (ASCA)

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

Patient/Relative Signature: [signature] Date: 1-28-2020

Relationship, if not patient: Date:

Physician Signature: Kristy A. Stead, MD Date: 2/5/20 12:33 PM

Witness to Patient Signature: [signature] Date 1/28/20

FAXED 1/28 @ 5:15 pm