Chemotherapy/Immunotherapy Consent Form
Non-Research Drugs And Treatment
(To Be Completed By Physician Obtaining Consent)

Physician (please print): _____ has informed me that I need chemotherapy/immunotherapy treatment that consists of the following:

List of chemotherapy/immunotherapy drugs to be administered (PLEASE PRINT): **Biosimilar products may be approved for use subject to third party payer preference.**	
1.	4.
2.	5.
3.	6.

Diagnosis: _____

The goal of this treatment is: ☐ Curative Other: _____

1. The physician above has fully explained to me, in language I understand, the nature of the proposed chemotherapy/immunotherapy drug(s), the purpose of treatment, potential benefits and risks or side effects, including potential problems that might arise during recuperation, as well as the likelihood of achieving the proposed goals. I have had ample opportunity to ask questions.

2. My physician has informed me about reasonable alternatives to the proposed chemotherapy/immunotherapy, the relative benefits and risks, and side effects related to such alternatives, as well as the risks of not receiving the treatment. Alternatives include:

   _____

3. I understand that there are potential benefits of this treatment if it is successful. I also understand that my doctor cannot be sure that the treatment will help me and no guarantee or assurance has been made as to the results obtained.

4. I understand a biosimilar (biological product) may be available for treatment. My provider has explained to me the biological product that may be used is highly similar to the original drug.

5. I have been advised that patients in childbearing years who undergo chemotherapy/immunotherapy may experience complications including:

   a. Altered ovarian or testicular function such that they may become infertile.

   b. If the patient or patient's spouse becomes pregnant while on chemotherapy/immunotherapy, the pregnancy may result in an abnormal outcome including a miscarriage, birth of an abnormal baby or other complication.

This treatment has been carefully explained to me verbally. Printed material specific to the treatment have been reviewed. This permission is based on knowledge and understanding of the elements of the therapy and an awareness of the risks, consequences, and discomforts. In rare instances these complications may result in my death. These side effects vary from drug to drug, and most commonly include, ***but are not limited*** to, the following as checked:

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- ☐ **Allergic Reaction**
- ☐ **Diarrhea**
- ☐ **Eye Reactions (dry, itchy, watery)**
- ☐ **Fatigue**
- ☐ **Forgetfulness**
- ☐ **Hair loss**
- ☐ **Hearing Loss**
- ☐ **Heart effects**
- ☐ **Infusion site reaction**
- ☐ **Kidney or bladder effects**
- ☐ **Light sensitivity**
- ☐ **Liver damage**
- ☐ **Loss of appetite**
- ☐ **Low blood cell count**
- ☐ **Lung effects**
- ☐ **Muscle or bone effects**
- ☐ **Nausea & Vomiting**
- ☐ **Numbness/tingling**
- ☐ **Risk of bleeding**
- ☐ **Risk of infection**
- ☐ **Secondary malignancy**
- ☐ **Sexual effects**
- ☐ **Skin effects (ulceration, rash, hand and foot)**
- ☐ **Sores of mouth and throat**
- ☐ **Other: _____**

I have also received instructions on precautions and how my family and I should handle my body fluids and secretions related to my chemotherapy/immunotherapy if required (not applicable for immunotherapy patients).

I understand clearly that I can stop my participation in treatment at any time and that such discontinuation will not prejudice my future medical care.

I was provided the opportunity to receive a copy of the consent form.

Patient/Agent/Relative/Guardian* (Signature)	Date	Time	Print Name	Relationship if other than patient

Telephonic Interpreter's ID #	Date	Time
OR		

Signature: Interpreter	Date	Time	Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature)	Date	Time	Print Witness Name

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.

Responsible Practitioner's Certification. I certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate. In the event that I was not present when the patient signed this form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained the consent from the patient. If applicable, I certify that outside pathology slides have been reviewed by the Hospital's Pathology Department.

Responsible Practitioner's Signature	Date	Time	Contact Information

Print Responsible Practitioner's Name