Patient Agreement to Systemic Therapy: Consent Form

Cyclophosphamide Intravenous

Patient's details / addressograph:	☐ Male ☐ Female
	Special requirements (e.g. other language/other communication method)
	Consultant:

Name of proposed course of treatment: Cyclophosphamide IV

Cyclophosphamide IV bolus on Day 1
Repeated every 2 - 4 weeks as specified by your Consultant

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

☐ I have discussed what the treatment is likely to involve (including inpatient / outpatient treatment, timing of the treatment, follow-up appointments) and location.
☐ Patient information leaflet given (ARUK or other)

The intended benefits
Treatment of disease ……

Significant, unavoidable or frequently occurring risks:

Potential side-effects: bruising or bleeding, anaemia (low number of red blood cells), hair loss, feeling sick (nausea) and being sick (vomiting), sore mouth or mouth ulcers, taste changes, tiredness and feeling weak, irritation of the bladder lining.

Less common but potentially life threatening side-effects: reduced resistance to infection which can lead to a potentially fatal blood infection

Other less common side-effects include: late effects include a very rare chance of a cancer

Some chemotherapy drugs can damage women's ovaries and men's sperm, with risk of infertility and early menopause in women. I have warned the patient about the likelihood of:

☐ early menopause in women ☐ infertility (in men and in women)

Some chemotherapy drugs may damage the development of a baby in the womb (foetus), leading to the many risks associated with an abnormal pregnancy. Therefore, I have discussed the issues of protected sex. This is an issue for both men and women. The patient has been advised not to become pregnant / not to get a partner pregnant during the period of treatment, and for 12 months (women) / 6 months (men) after treatment has completed.

Any other risks:

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Clinician Signature

Signed…… Date ……

Full Name (print) ……..…. / …… Job Title……...
(Forename) (Surname)

Statement of patient

Patient Signature

Please read this form carefully, which describes the benefits and risks of the proposed treatment. You have the right to change your mind at any time, including after you have signed this form.

I agree to undergo chemotherapy. I understand the treatment and am aware of the potential side-effects arising from this treatment.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate training and experience.

Signed…… Name……..……..

Date…….....

A witness should sign below if the patient is unable to sign but has indicated his or her consent.

Signature …… Date ……..…..……

Name (PRINT) ……..……..…

Statement of interpreter (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand.

Signed ……..……..… Name (PRINT) ……..……..…… Date……

Confirmation of consent (to be completed by the chemotherapy nurse when the patient attends for the first cycle)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the treatment to go ahead.

Signed ……..……..… Name (PRINT) ……..……..…… Date……

Copy accepted by patient: yes/no (please ring)

Copy to be retained in patient's notes