

Patient Agreement to Systemic Therapy: Consent Form	
IPE	
Patient's details / addressograph:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Special requirements (e.g. other language/other communication method)
	Consultant:

Name of proposed course of treatment: IPE

Cisplatin IV infusion and Ifosfamide IV infusion on Days 1 to 5
 Etoposide IV infusion on Days 1, 3 and 5
 Repeated every 3 weeks for 4 cycles

Macmillan leaflet(s) given

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.

The intended benefits

- Curative – to give you the best possible chance of being cured
- Palliative – the aim is not to cure but to control or shrink the disease. The aim is to improve both quality of life and survival
- Adjuvant – therapy given after surgery to reduce the risk of recurrence of cancer
- Neo-adjuvant – therapy given to shrink the cancer before surgery or radiotherapy

Significant, unavoidable or frequently occurring risks:

Common side-effects: bruising or bleeding, anaemia (low number of red blood cells), feeling sick (nausea) and being sick (vomiting), hair loss, damage to the lining of your bladder, blood in your urine, tiredness and feeling weak, taste changes

Less common but potentially life threatening side-effects: allergic reactions, reduced resistance to infection which can lead to a potentially fatal blood infection, CNS toxicity (drowsiness and confusion are usually the first symptoms); very rarely, damage to your heart or lungs

Other less common side-effects include: numbness or tingling in the hands or feet, sore mouth and ulcers, changes in hearing, diarrhoea, damage to your kidneys, changes to your liver, Raynaud's disease (poor circulation in fingers and toes in cold weather); late effects include a rare chance of a second cancer

Cancer can increase your risk of developing a blood clot (thrombosis), and having chemotherapy may increase this risk further. A blood clot may cause pain, redness and swelling in a leg or arm, or breathlessness and chest pain - you must tell your doctor straight away if you have any of these symptoms.

Some chemotherapy drugs can damage men's sperm, with a risk of infertility.
 I have warned the patient about the likelihood of infertility

Some chemotherapy drugs may damage the development of a baby in the womb (fetus), leading to the many risks associated with an abnormal pregnancy. Therefore, I have discussed the issues of protected sex. The patient has been advised not to get a partner pregnant during the period of treatment, and for 6 months 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

Reason for Update: N/A	Checked and approved by Consultant: Dr J Money-Kyrle
Version: 1	Date: 12.10.15