Patient Agreement to Systemic Therapy: Consent Form

Pazopanib

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

Name of proposed course of treatment:

Pazopanib
Tablets taken by mouth once daily continuously, until disease progression

Macmillan leaflet 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 before surgery or radiotherapy to shrink the cancer

Significant, unavoidable or frequently occurring risks:

Common side-effects: tiredness and feeling weak, hand/foot skin reaction (redness of the palms of your hands or soles of your feet, sore or swollen hands or feet), sore mouth and ulcers, effects on the skin (rash, redness, dryness or itching), skin colour tone changes, thinning and loss of hair colour, high blood pressure, diarrhoea, feeling sick (nausea) or being sick (vomiting), thyroid problems (symptoms of an underactive thyroid may include tiredness, weight gain, constipation, aches, feeling cold, dry skin and hair), elevated liver transaminases (AST, ALT), taste changes, loss of appetite, headache

Less common but potentially life threatening side-effects: liver failure, heart problems, problems with blood supply to your heart leading to chest pain or angina, increased risk of stroke, gastro-intestinal perforation, bleeding into the lungs

Other less common side-effects include: unusual bleeding and bruising (for example, your gums may bleed, nosebleeds, you may bruise more easily or notice blood in your urine), reduced resistance to infection

Rarely, cases of reversible encephalopathy with seizures, headache, altered mental status and visual disturbances have been reported.

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

Pazopanib may have an effect on fertility.

☐ I have warned the patient that there is an unknown risk of pazopanib affecting fertility (in men and in women)

Pazopanib 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 2 weeks after treatment has stopped.

Any other risks:

……..

……..

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 ……..…… Date ……..…….

Name (PRINT) ……..……

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

Copy to be retained in patient's notes