

Patient Agreement to Systemic Therapy: Consent Form	
Sunitinib	
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:**Sunitinib**

Renal cancer or GIST: Sunitinib capsules taken by mouth once daily for 4 weeks, followed by a 2 week rest period.

Pancreatic neuroendocrine: Sunitinib capsules taken by mouth once daily continuously
Treatment continued at the discretion of the treating doctor

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: 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, 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), loss of skin colour (becoming yellow in tone), thinning and loss of hair colour, high blood pressure, diarrhoea, feeling sick (nausea), thyroid problems (symptoms of an underactive thyroid may include tiredness, weight gain, constipation, aches, feeling cold, dry skin and hair).

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

Other less common side-effects include: pancreatitis, delay in wound healing

Cancer can increase your risk of developing a blood clot (thrombosis), and sunitinib 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.

Sunitinib may have an effect on fertility.

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

Sunitinib 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.

Any other risks:

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Clinician Signature	
Signed.....	Date
Full Name (print) /	Job Title.....
(Forename)	(Surname)

Statement of patient

<p>Patient Signature</p> <p>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.</p> <p>I agree to undergo chemotherapy. I understand the treatment and am aware of the potential side-effects arising from this treatment.</p> <p>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.</p> <p>Signed..... Name.....</p> <p>Date.....</p> <p>A witness should sign below if the patient is unable to sign but has indicated his or her consent.</p> <p>Signature Date</p> <p>Name (PRINT)</p>
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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

Reason for Update: N/A	Checked and approved by Consultant: Dr A Michael
Version: 1	Date: 25.8.15