

| <b>Patient Agreement to Systemic Therapy: Consent Form</b> |                                                                                                        |
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <b>TPF</b>                                                 |                                                                                                        |
| Patient's details / addressograph:                         | <input type="checkbox"/> Male <span style="margin-left: 200px;"><input type="checkbox"/> Female</span> |
|                                                            | Special requirements<br>(e.g. other language/other communication method)                               |
|                                                            | <b>Consultant:</b>                                                                                     |

**Name of proposed course of treatment:****TPF (Docetaxel, Cisplatin + Fluorouracil)**

Docetaxel IV infusion and Cisplatin IV infusion on day 1

Fluorouracil (continuous infusion over 4 days in a portable infusion device) also starting on day 1

Repeated every 3 weeks for up to 3 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 before surgery or radiotherapy to shrink the cancer

**Significant, unavoidable or frequently occurring risks:**

**Common side-effects:** hair loss, feeling sick (nausea) and being sick (vomiting), bruising or bleeding, anaemia (low number of red blood cells), sore mouth and ulcers, constipation, diarrhoea, numbness and tingling in hands and feet, soreness and redness on the palms of your hands and soles of your feet, fluid retention (you may notice you gain weight and/or you develop swollen ankles), changes in hearing (due to cisplatin), taste changes, loss of appetite, tiredness, your kidney function may be affected

**Less common but potentially life threatening side-effects:** chest pain or angina; reduced resistance to infection which can lead to a potentially fatal blood infection; allergic reaction

**Other less common side-effects include:** nail changes, watery or sore eyes, aching or pain in joints or muscles.

If docetaxel accidentally leaks outside the vein during administration, it can cause damage to the surrounding tissues, including potential long-term damage to both the function and appearance of the area. This is not common, but if it happens, nursing staff are trained to minimise the risks of longer term damage.

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 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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|                                 |                |
|---------------------------------|----------------|
| <b>Clinician Signature</b>      |                |
| Signed.....                     | Date .....     |
| Full Name (print) ..... / ..... | Job Title..... |
| (Forename)                      | (Surname)      |

**Statement of patient**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>Patient Signature</b></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><b>I understand</b> 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><b>A witness should sign below if the patient is unable to sign but has indicated his or her consent.</b></p> <p>Signature ..... Date .....</p> <p>Name (PRINT) .....</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**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 S Whitaker |
| Version: 1             | Date: 18.8.15                                     |