Patient Agreement to Systemic Therapy: Consent Form

High dose Methylprednisolone

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

Name of proposed course of treatment: High dose Methylprednisolone

Methylprednisolone IV infusion or oral once a day on days 1 to 5

Repeated every 4 weeks for up to 6 cycles

Macmillan/CRUK/other 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

☐ Disease control - the aim is not to cure but to control the disease. The aim is to improve both quality of life and survival

Significant, unavoidable or frequently occurring risks:

Common side-effects: irritation of the stomach lining, increased appetite, changes in blood sugar levels, fluid retention, changes in behaviour (mood swings, difficulty sleeping, anxiety or irritability)

Less common but potentially life-threatening side-effects: reduced resistance to infection which can lead to serious infections

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

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 high dose Methylprednisolone treatment. 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