| **Patient Agreement to Systemic Therapy: Consent Form**<br>**MIDAC** | |
|---|---|
| Patient's details / addressograph: | ☐ Male ☐ Female |
| | Special requirements<br>(e.g. other language/other communication method) |
| | **Consultant:** |

**Name of proposed course of treatment: MIDAC**

**Mi**toxantrone IV bolus once daily on days 1-5
Cytarabine (Also known as **Ara-C**) IV infusion twice a day on days 1-3

Given as one cycle

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**

☐ Curative – to give you the best possible chance of being cured
☐ Improved survival

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

**Common side-effects**: low white blood cells (neutropenia) with risk of infection, low red blood cells (anaemia), low platelets with risk of bleeding (you will be given red blood cell and platelet transfusions), feeling sick (nausea) and being sick (vomiting), hair loss, sore mouth and ulcers, diarrhoea or constipation, altered liver function which will be monitored throughout the treatment, rash, tiredness and feeling weak
Cytarabine can cause gritty and sore eyes (conjunctivitis) and you will be given eye drops to prevent this or reduce the severity.

**Less common but potentially life-threatening side-effects:** severe infection causing organ failure.

**Other less common side effects include:** Rarely, cytarabine can affect your nervous system and you must tell your doctor if you feel dizzy or suffer with confusion whilst receiving this treatment.
Changes in the way your heart works - rarely, mitoxantrone may cause long-term damage to the heart. Late effects include a very 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 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:

……..
……..

**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 MIDAC 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**