Patient Agreement to Systemic Therapy: Consent Form

Dacarbazine for melanoma

Patient identification	☐ Male ☐ Female
	Special requirements:
	Consultant:

Introduction

You need to give your permission before you receive any type of medical treatment or examination. Certain treatments require the permission to be recorded in writing because there are special risks and considerations. This document is to record that an explanation has been given by an appropriate clinician and that you agree to the treatment, having assessed for yourself the processes, intended benefits and potential risks involved.

Statement of Health Professional

I have discussed the following aspects of the treatment.

The processes involved

- ☐ The drug is given as an intravenous infusion over 1-2 hours, every three weeks. The right dose for you is estimated according to your height and weight. Each three week period is called one cycle. The normal number of cycles is six, but this may be extended if you are tolerating the drug and it is working well.
- ☐ I have discussed the system of clinic appointments and blood tests, and how we will assess whether the drug is working.

The intended benefits

- ☐ In around 20% of people taking this drug, the melanoma will shrink to some extent. In an extra group of people, the growth of the melanoma will be stopped
- ☐ When it works, the typical length of time it works for is around 4-6 months.
- ☐ These figures are from clinical trials of many patients, and your individual experience may be very different. Dacarbazine may not have any beneficial effect at all for you, or it may work for considerably longer than the average.

Side effects

- ☐ Tiredness
- ☐ Nausea and loss of appetite
- ☐ Sensitivity to the sun
- ☐ Suppression of the bone marrow, including anaemia, bruising and infection risks, which can sometimes require transfusions and very occasionally be severe or life threatening

Less common side effects

- ☐ A metallic taste in the mouth
- ☐ Hair thinning may occur; complete hair loss is rare
- ☐ Flu-like symptoms for about a week after the treatment
- ☐ Inflammation around the drip site; very rarely long-term damage to skin or tissues from the infusion
- ☐ Reduction in fertility in men and women, change in menstruation, occasionally early menopause
- ☐ Diarrhoea
- ☐ Blood clots in the leg or moving to the lung (deep venous thrombosis or pulmonary embolism)

Precautions

- ☐ Women of childbearing potential should use effective methods of contraception during therapy and for 12 months after stopping. Men should use barrier contraception during therapy and for 6 months after stopping.
- ☐ You should avoid sun exposure for 3-5 days after each infusion, using clothing and/ or sunscreen.
- ☐ It is likely to be safe to receive the 'flu vaccination in the few days prior to each dacarbazine infusion, but please check with your doctor.

Other considerations

- ☐ I have discussed the alternatives to this treatment and the associated risks
- ☐ I have discussed with you any special risks that might apply to you as an individual
- ☐ Additional information is attached to this form. You have agreed to read this and we will give you an opportunity to answer any further questions or concerns before you start treatment.

Clinician Signature

Sign ....

Print name ....

Date ....

Job title ....

Statement of Patient

- I have carefully read this form, which describes the benefits and risks of the proposed treatment.
- I have the right to change my mind at any time, including after I have signed this form
- I agree to undergo drug therapy. I understand the treatment and am aware of the potential side effects arising from the treatment.
- I understand that you cannot give me a guarantee that a particular person will perform or manage the treatment. The person will, however, have appropriate training and experience.

Patient Signature

Sign ....

Print name ....

Date ....

Job title ....

Statement of witness if required

- The patient is unable to sign but has indicated his or her consent.

Witness Signature

Sign ....

Print name ....

Date ....

Job title ....

Statement of interpreter if required

- 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.

Interpreter Signature

Sign ....

Print name ....

Date ....

Job title ....

Confirmation of consent

- Completed by the chemotherapy nurse at first treatment attendance
- 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.

Healthcare Practitioner Signature

Sign ....

Print name ....

Date ....

Job title ....

Record

☐ Hardcopy accepted by patient
☐ Hardcopy for notes
☐ Scanned