Patient Agreement to Systemic Therapy: Consent Form

Olaparib

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

Name of proposed course of treatment:

Olaparib
Tablets taken by mouth twice daily continuously, until disease progression

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: tiredness and feeling weak, diarrhoea, feeling sick (nausea) or being sick (vomiting), indigestion, taste changes, loss of appetite, headache, dizziness, anaemia (low number of red blood cells), reduced kidney function.

Less common but potentially life threatening side-effects: reduced resistance to infection which can lead to a potentially fatal blood infection; rarely, development of myelodysplastic syndrome (MDS) or acute myeloid leukaemia (AML); lung or breathing problems (pneumonitis)

Other less common side-effects include: unusual bleeding and bruising (for example, nosebleeds, you may bruise more easily or notice blood in your urine)

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 chemotherapy. 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 ……..…… Date ……..…….

Name (PRINT) ……..……

Copy accepted by patient: yes/no (please ring)

Copy to be retained in patient's notes