UMC HEALTH SYSTEM

UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

DISCLOSURE AND CONSENT- CHEMOTHERAPY / IMMUNOTHERAPY

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) voluntarily request Doctor(s)_____as my physician(s), and such associates, technical assistants and other health care providers as they may deem necessary, to treat my **condition** which has been explained to me (us) as (**lay terms):**

_____

2. I (we) understand that the following surgical, medical, and/or diagnostic **procedures/treatment** are planned for me and I (we) voluntarily consent and authorize (**lay terms):** Administration of chemotherapy/ immunotherapy drugs**:**_____

_____or an equivalent FDA-approved biosimilar.

3. I understand that the above treatment has been selected from several possible alternative treatments and that I am free to withdraw from treatment anytime I may wish.

4. I understand that chemotherapy can be harmful to an unborn child. It is important to tell the doctor if I think I may be pregnant. It is important for both men and women who are being treated with chemotherapy and who are sexually active and fertile and who have a fertile partner to use a reliable form of birth control (birth control pills, a reliable barrier method, or a hormonal implant as recommended by your physician). I have discussed possible ways of preserving my fertility with my doctor if applicable.

5. Please initial _____**Yes**_____**No**

I consent to the use of blood and blood products as deemed necessary. I (we) understand that the following risks and hazards may occur in connection with the use of blood and blood products:

a. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
b. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys and immune system.
c. Severe allergic reaction, potentially fatal.

6. I (we) understand that no warranty or guarantee has been made to me as to the result or cure.

7. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the administration of chemotherapy/immunotherapy planned for me. I (we) realize that common to chemotherapy/immunotherapy administration is the potential for: Infection, blood clots in veins and lungs, hemorrhage, allergic and allergic-like reactions, anemia, fatigue, constipation, diarrhea, loss of appetite, mouth sores, nausea or vomiting, weight gain or loss, liver damage, hair loss, skin and nail darkening, skin ulceration at injection site, skin rash, light & temperature sensitivity, numbness or tingling, hearing loss, heart damage, kidney damage, low platelet count causing bleeding, low white blood cell count, menopausal symptoms, menstrual irregularities, sterility, dizziness, forgetfulness, cognitive impairments, secondary malignancy, muscle aching or weakness. I (we) also realize that unexpected side effects may occur in addition to those noted above. In rare instances, cancer treatment can cause life-threatening complications and death. Such effects have been explained to me and described in the Drug Information Sheets, copies of which have been given to me and I (we) realize the chemotherapy may have to be changed

8. _____ (Patient Initials) A healthcare professional has provided and reviewed with me written information on the drugs I will receive. I HAVE HAD THE CHANCE TO ASK ANY QUESTIONS ABOUT THE DRUGS I WILL RECEIVE AND AM SATISFIED WITH THE INFORMATION PROVIDED.

9. My healthcare team has explained my treatment plan in detail. My doctor has discussed with me other methods of treating this disease and the risks and benefits of treatment. There is no guarantee that this treatment will give me the same results that other patients have received. If I change my mind and decide to stop treatment at any time, my doctor will continue to provide for my care in the future.

10. I (we) have read the above information. I understand the possible risks and benefits of the recommended treatment plan. I agree to accept the treatment and authorize Dr._____and his/her healthcare team to carry out the treatment plan.

IF I (WE) DO NOT CONSENT TO ANY OF THE ABOVE PROVISIONS, THAT PROVISION HAS BEEN CORRECTED.

_____ _____ A.M. (P.M.)
Date Time

_____
*Patient/Other legally responsible person signature Relationship (if other than patient)

_____
*Witness Signature Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415 ☐ TTUHSC 3601 4th Street, Lubbock, TX 79430
☐ UMC Health & Wellness Hospital 11011 Slide Road, Lubbock TX
☐ OTHER Address:_____
Address (Street or P.O. Box) City, State, Zip Code

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No_____
Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No_____
Printed name of interpreter Date/Time

Date procedure is being performed: _____

1296

UMC HEALTH SYSTEM
UNIVERSITY MEDICAL CENTER
Lubbock, Texas

Patient Label Here

Date _____

Resident and Nurse Consent Checklist

Instructions for form completion

Note: Enter "not applicable" or "none" in spaces as appropriate. Consent may not contain blanks.

Section 1: Enter name of physician(s) responsible for procedure and patient's condition in lay terminology. **May not be abbreviated.**

Section 2: Enter name of procedure(s) to be done. Use lay terminology.

Section 6: Enter risks as discussed with patient.

A. Risks for procedures on List A must be included. Other risks may be added by the Physician.
B. Procedures on List B or not addressed by the Texas Medical Disclosure panel do not require that specific risks be discussed with the patient. For these procedures, risks may be enumerated or the phrase: "As discussed with patient" entered.

Patient Signature: Enter date and time patient or responsible person signed consent.

Witness Signature: Enter signature, printed name and address of competent adult who witnessed the patient or authorized person's signature

If the patient does **not** consent to a specific provision of the consent, the consent should be rewritten to reflect the procedure that the patient (authorized person) is consenting to have performed.

For additional information on informed consent policies, refer to policy SPP PC-17.

Consent

☐ Name of the procedure (lay term)	☐ No medical abbreviations
☐ No blanks left on consent	☐ Signatures obtained

Orders

☐ Procedure Date	☐ Procedure
☐ Diagnosis	☐ Signed by Physician & Name stamped

Nurse_____Resident_____Department _____

THIS FORM IS NOT PART OF THE MEDICAL RECORD