## Arizona Oncology Oral Consent Form

_____
Patient Last Name Patient First Name

_____
Medical Record Number

_____
Diagnosis

_____
Goals of Therapy

_____
Planned Duration of Treatment

_____
Treatment Regimen & Schedule

I hereby authorize Dr. _____ and his or her designated nurse to begin oral treatment that may include oral chemotherapy. I understand that other health professionals may help my doctor provide this treatment. I have received a detailed explanation of my treatment plan, including, at a minimum, chemotherapy drugs, doses, anticipated duration, and goals of therapy. Possible alternative methods of treatment and the risk of injury despite precautions have been explained to me. No guarantee or assurance has been given by anyone as to the results which may be obtained. I have been given the opportunity to ask questions concerning the above therapy and these questions have been answered to my satisfaction. I understand that I may withdraw my consent for treatment and stop treatment at any time and such withdrawal will not prejudice my future medical care.

I understand that chemotherapy medications may have short-term and long-term side effects. A provider has talked to me about the side effects (listed on page 2) that I might experience because of my treatment. I could have side effects from my treatment that are not listed here. Each patient can respond differently to treatments.

Safe handling of chemotherapy: **Keep in a safe place and out of the reach of children**.

- Wash hands before and after handling oral medications. Wash any areas that come in contact with chemotherapy.
- Store at room temperature or refrigerate as directed on the label. Do not crush tablets or open capsules.
- Do not dispose of in trash or down the sink. Disposal is available at many local law enforcement centers. The FDA website (http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm) may provide further information.

I understand that I can contact a healthcare provider at this office at any time if I have questions, and that I should call the office for any of the following: temperature greater than 101° F, bleeding, uncontrolled pain, shortness of breath, chest pain or discomfort, uncontrolled vomiting, persistent diarrhea, dizziness, or any other unusual or worrisome symptoms. The phone number for the office is: _____.

I have read the above statement and understand the potential risks and benefits of my therapy and agree to accept treatment.

_____
Patient Signature (or Legal Representative) Date

I have explained the treatment, expected response and goals, side effects, and risks to the above signed patient.

_____
Provider Signature Nurse Signature Date

**Pregnancy SHOULD be avoided during treatment. Fertility risks and options may be reviewed.**

- ❑ Allergic-Type Reactions
- ❑ Bladder Damage
- ❑ Bleeding
- ❑ Brief Periods of Forgetfulness
- ❑ Changes in Appetite or Weight
- ❑ Constipation
- ❑ Cough or Sore Throat
- ❑ Dehydration
- ❑ Diarrhea
- ❑ Dizziness or Headache
- ❑ Edema/Fluid Retention
- ❑ Fatigue/Tiredness
- ❑ Hair Loss
- ❑ Hand/Foot Syndrome
- ❑ Heart Damage
- ❑ Inability to Sleep
- ❑ Kidney Damage
- ❑ Liver Damage
- ❑ Life-Threatening Complications
- ❑ Low Red Blood Cell Count (Anemia)
- ❑ Low Platelets (Bruising/Bleeding)
- ❑ Low White Blood Cells (Infection)
- ❑ Lung Damage
- ❑ Menopausal Symptoms
- ❑ Menstrual Irregularities
- ❑ Mouth Sores
- ❑ Muscle or Joint Aches or Back Pain
- ❑ Nausea, Vomiting, Abdominal Pain
- ❑ Numbness or Tingling
- ❑ Reproductivity/Fertility Changes
- ❑ Sexual Effects
- ❑ Shortness of Breath
- ❑ Skin Rash/Sensitivity to Light
- ❑ Thyroid Damage
- ❑ Visual Changes

Other _____