

Oncology / Haematology Centre Consent form 1

Patient agreement to investigation or treatment

DGH identification label:
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:

Addenbrooke's identification label:
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:

Responsible health professional/job title:

Special requirements
 (For example, other language/other communication method)

Name of proposed procedure or course of treatment

- | | | |
|---------------------|--|-------------------------|
| Radiotherapy | <input type="checkbox"/> External Radiotherapy | Site/side of body |
| | <input type="checkbox"/> Brachytherapy | Site..... |
| | <input type="checkbox"/> Radio-Isotope treatment | Site..... |
| Systemic Therapy | <input type="checkbox"/> Biological Therapy | Regimen |
| | <input type="checkbox"/> Cytotoxic Chemotherapy | Regimen |
| Invasive Procedures | <input type="checkbox"/> Immunotherapy | Regimen |
| | <input type="checkbox"/> Central Venous Access Device (CVAD) Insertion | |
| | <input type="checkbox"/> Lumbar Puncture with Intrathecal Chemotherapy | |
| | <input type="checkbox"/> Bone marrow aspirate +/- trephine | |
| | <input type="checkbox"/> EUA, please specify | |

Statement of health professional

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. In particular, I have explained:

- The intended benefits of the procedure
- 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 especially if it is causing specific symptoms. The aim is to keep you as well as possible for as long as possible.
- Diagnosis**
- Any serious or frequently occurring risks from the procedures including those specific to the patient
- Any extra procedures that might become necessary during the course of treatment
- The following information leaflet has been provided: Issue no./ Issue date:

This procedure will involve: General and/or regional anaesthesia Local anaesthesia Sedation

Health professional's signature **Date:**

Name (PRINT): Job title:

Contact details (if patient wishes to discuss options later)

I have offered the patient information about the procedure but s/he has declined information.

Statement of the interpreter (where appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature **Date:**

Name (PRINT):

Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which described the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. **You have the right to change your mind at any time, including after you have signed this form.**

For staff use only:
Surname:
First names:
Date of birth:
Hospital no:
Male/Female:
(Use hospital identification label)

Please read the following:

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

I understand that data about me will be held electronically and may be passed between organisations to facilitate my care and research and to monitor and improve the quality of service.

I understand that any tissue (including blood) removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

I understand that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

I understand that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

Please tick boxes to indicate you either agree/disagree to the three points below. **Yes** **No**

I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** **If you wish** to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

I agree to the use of photography for the purpose of diagnosis and treatment.

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

Female patients between the age of 12 and 50 years please read the following statements.

I confirm that I am not pregnant

I understand that I need to avoid becoming pregnant during the course of my treatment

If I think that I might be pregnant, I will inform the staff treating me.

Radiotherapy only:

I agree to the use of permanent skin marks, for the purpose of accurate treatment.

Patient's signature: **Date:**

Name (PRINT):

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

Witness' signature: **Date:**

Name (PRINT):

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature:..... **Date:**

Name (PRINT): **Job Title:**

Important notes for staff: (tick if applicable)

- Patient has consented to participation in a clinical trial
- See also advance directive/living will (eg Jehovah's Witness form)
- The patient has withdrawn consent (ask patient to sign/date here)

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