NHS
Salisbury
NHS Foundation Trust

# Haematology/Oncology Department
# Patient agreement to Systemic Therapy

# Chlorambucil

Designed in compliance with the Department of Health Consent Form 1

| **Patient details (or pre-printed label)** | |
|---|---|
| Patients NHS Number or Hospital Number | |
| Patients Surname / Family Name | |
| Patients First Name(s) | |
| Date of Birth | |
| Sex | |
| Responsible Healthcare Professional | |
| Job Title | |
| Special Requirements e.g. other language or other communication method | |

Informed consent is obtained in accordance with the requirements of the HT Act 2004, the Human Tissue Regulations 2007 and the HTA's Codes of Practice.

**Tissue samples**

Tissues may be removed during your procedure for diagnostic examination by a histopathologist (a specialist doctor who looks at tissue from patients). Tissue samples needed for diagnosis are stored by the laboratory for several years. The stored tissue may be anonymously used for laboratory quality control, audit and education. These are essential activities for maintaining high quality diagnostic pathology services. Any remaining excess tissue removed is incinerated.

The specimen may be digitally photographed and the images temporarily stored in the laboratory as part of the diagnostic process. Other completely anonymised images may also be used for quality assurance, audit and education purposes.

Occasionally stored tissues and photographs might be used for research projects. Any such research will have been approved by a research ethics committee (REC). Usually any pathology specimens used for research are made completely anonymous, so that individual patients cannot be identified in any way. If this is not possible, the REC will require the researcher to contact you and ask permission to use your stored tissue
or photographs. You would then be free to decide whether or not to allow the use of the material. Your decision would not in any way affect your medical care.

Patient identifier/label

| Name of proposed procedure or course of treatment | | |
|---|---|---|
| **Systemic therapy** | ☐ | Cytotoxic chemotherapy (Chlorambucil)) |
| | ☐ | Immunotherapy |
| | ☐ | Both |
| | ☐ | Lumbar puncture with intrathecal chemotherapy |

**Statement of health professional** (To be filled in by health professional with appropriate knowledge of the proposed procedure, as specified in the consent policy).

I have explained the procedure to the patient. In particular, I have explained:

**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** - chemotherapy given after surgery to reduce the risk of recurrence of cancer.
- ☐ **Neo-adjuvant** - chemotherapy given before surgery to shrink the cancer and reduce the risk of recurrence of cancer.

**General risks of the therapy**

Lowered resistance to infection, bruising or bleeding, tiredness, anaemia, feeling sick (nausea) or being sick (vomiting), loss of appetite, changes to the lungs, skin rashes, fits or seizures, changes to the liver, diarrhoea, sore mouth or ulcers, loss of fertility, life-threatening toxicities.

❑ The following leaflet / tape has been provided: _____ Version: ___

❑ The Pembroke Unit Alert card has been given to the patient.

❑ The Hand-held diary has been given to the patient (if appropriate).

| | |
|---|---|
| Signed: | Date: |
| Name (PRINT) | Job Title: |

**Contact Details** (if patient wishes to discuss options later) _____

**Statement of interpreter** (where appropriate). I have interpreted the information above to the patient to the best of my ability and in a way I believe s/he can understand.

Signature of Interpreter _____ Name (print) _____ Date _____

**Copy accepted by patient: yes / no (please ring)**
**If yes, please copy all pages and give to the patient**

Patient identifier/label

## Statement of patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of page 2, which describes 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.

**I agree** to the procedure or course of treatment described on this form.

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

**I understand** that any procedure in addition to the one described on this form will only be carried out if it is necessary to save my life or 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 which I do not wish to be carried out without further discussion. _____

_____

Female patients between the age of 16 and 50 please read the following statements:

| | |
|---|---|
| ☐ | I confirm that I am not pregnant. |
| ☐ | I understand that I must avoid becoming pregnant during the course of treatment and for 12 months afterwards. |
| ☐ | If I think I might be pregnant, I will inform the staff treating me. |

Male patients please read the following statement and tick box to confirm that you have understood:

| | |
|---|---|
| ☐ | While undergoing chemotherapy and for 12 months afterwards, you and your partner must use adequate contraception to ensure that pregnancy does not occur. |

| Patient's signature: | Name (PRINT): | Date: |
|---|---|---|
| | | |

**A witness should sign below if the patient is unable to sign, but has indicated his or her consent. Young people/children may also like a parent to sign here.**

| Signature: | Name (PRINT): | Date: |
|---|---|---|
| | | |

**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.

| Signed: | Date: |
|---|---|
| Name (PRINT): | Job Title: |

**Important notes: (tick if applicable)**

- ☐ See also advanced directive/living will (e.g. Jehovah's Witness form).
- ☐ Patient has withdrawn consent (ask patient to sign/date here) _____
- ☐ Patient has agreed to participation in clinical trial (see separate consent form).