 

Haematology Department :

GCSF Mobilisation and stem cell harvest +/- Plerixafor

Designed in compliance with the Department of Health Consent Form 1

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| --- |
| **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 anonymized 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** |
| **Invasive procedure** |  | Bone marrow biopsy under sedation |
|  |  | Other (please specify) Stem cell mobilisation and harvest  |
| The procedure will involve: Local anaesthesia   |

**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:

|  |  |
| --- | --- |
|  | **Therapeutic** -To harvest stem cells for an Autologous Stem cell Transplant. |

**General risks of the procedure/therapy:**

**GCSF: Bone and muscle pain, injection site discomfort, headache, breathlessness, fatigue, DVT, stroke, Splenic rupture (very rare).**

Harvest: **Fatigue, feeling cold, dizziness, tingling/numbness in lips, face, hands, feet, muscle cramp, low blood pressure, altered electrolytes.**

Plerixafor :low blood pressure, nausea, diarrhoea or constipation, muscle/bone aches, headache, fatigue

**Any extra procedure**s which may become necessary during the procedure

**Calcium tablets +/- infusion, tablets or infusion to correct altered electrolytes, blood transfusion**.

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

* The following leaflet / tape has been provided:WBMT: Salisbury Auto GCSF Alone PBSC Mobilisation and Harvest. Version:

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

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

**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

Patient identifier/label

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have information as listed on page 2, which describes the benefits and risks of the proposed treatment. 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.

|  |  |  |
| --- | --- | --- |
| 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: |

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

# 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).