

Revised: 11/2015

Consent for Chemotherapy/Biotherapy, **ESHAP**

Condition for which treatment is proposed: _____

1. I hereby authorize my physician, Dr _____, and/or such other staff physicians or resident physicians as my physician may designate, to administer to me (or the patient for whom I consent) the following chemotherapy consisting of:

Etoposide (VP-16) Methylprednisolone Cytarabine Cisplatin

The plan for my course of treatment is for _____ cycles of therapy, with each cycle given about every _____ days.

The goal(s) of this treatment is (are) to:

_____ 1. Become free of my cancer with the hope that it will not return.
provider initials

_____ 2. Slow the progression of my cancer, relieve my symptoms and help prevent future
provider initials problems from my cancer.

2. My physician has discussed with me the items that are briefly summarized below:
- The nature and purpose of the proposed therapy is to administer **chemotherapy/biotherapy** (drugs to fight my cancer, which may also have other effects on my body) by mouth and/or by vein or by other type of injection. **Chemotherapy** usually refers to drugs which directly kill cancer cells, **Biotherapy** refers to either drugs which change my immune system to better fight my cancer or antibodies (so-called targeted treatments) which bind to cancer cells and help kill them. Sometimes several types of agents are combined in a plan of therapy. It is possible that this therapy may not be effective and my disease might progress.
 - Chemotherapy** may cause nausea, vomiting, loss of appetite, mouth sores, hair loss, fatigue, a lowering of the white blood cell count (which can lead to a serious infections), a lowered platelet count (which can lead to bleeding), and a decrease in my red blood cell count (which can lead to shortness of breath, a rapid heart beat or weakness). Due to these low blood counts, I may require red blood cell or platelet transfusions. My doctor will give me appropriate medications to try to decrease the severity of any side effects. Other side effects could occur, rarely death. It is important that I call my physician or nurse-coordinator with problems which occur during the course of my treatment. I always have the right to refuse therapy at any time.



- c. The side effects of **Biotherapy** agents are often different from the side effects of chemotherapy drugs and depend on which agents I will receive. These are listed below by each drug.
- d. **Chemotherapy long-term side effects** can include injury to lungs, heart, liver and/or bladder. Acute leukemia can also develop as a result of chemotherapy.
- e. **Chemotherapy usually has an adverse effect on sperm and eggs** and can cause me to be unable to have children. Chemotherapy can have harmful effects on an unborn child. If I am a woman, it is important to tell my physician if I think I may be pregnant. It is possible to conceive a child during treatment with chemotherapy. It is important that both men and women who are being treated with chemotherapy and who are sexually active, fertile, and who have a fertile partner use a reliable form of birth control (birth control pills, a reliable barrier method or a hormonal implant.)
- f. **Venipuncture:** You (or the patient for whom you consent) may require venipuncture (putting a needle into a vein to remove blood or administer treatment). The discomfort associated with venipuncture is a slight pinch or pinprick when the sterile needle enters the skin. The risks of venipuncture include mild discomfort and/or a black or blue mark at the site of the needle puncture. Less commonly, a small blood clot, infection or bleeding may occur at the needle puncture site. When therapy is administered into a vein, there is also a small risk of either infection in the bloodstream or the drug leaking outside the vein causing tissue irritation or damage.

The drugs which will be used for my planned chemotherapy/biotherapy and their specific side-effects:

Etoposide may cause decreased energy, skin rash, pain and inflammation at infusion site, and temporary low blood pressure. There is a potential of a build up of fluid around the heart. Vision problems, including blindness, headache, dizziness, confusion are rare side effects associated with Etoposide. Other side effects include muscle cramps, a decrease in the function of my nervous system, decreased kidney function, increased blood pressure, excess acidity throughout the body due to abnormal metabolism, allergic reactions, weight loss, abdominal pain, constipation, aftertaste, difficulty in swallowing, swollen glands, increased levels of certain chemicals in the liver, a change in the color of my skin. In rare cases, acute leukemia may develop after treatment with Etoposide

Methylprednisolone can cause loss or increase of appetite, weight gain, aggravation of ulcers, rash, facial hair growth, acne, bruising of the skin, redness of the face, menstrual changes, headache, loss of sleep, dizziness, depression, psychosis, a sense of well being, seizures, muscle weakness, fluid retention, an increase in blood pressure, irritation or inflammation of the veins, increased pressure in the eyes, cataracts, a change in metabolism, an increase in white blood cells, back pain, osteoporosis (loss of calcium from the bone tissue resulting in bones that break easily), viral, bacterial and fungal infections, including herpes, delayed wound healing, muscle wasting. This drug could cause abnormal reactions to skin tests. Other side effects include a protrusion of the eyes and skin cell death.



Cytarabine can cause weight loss, difficulty in swallowing, kidney problems, flu-like symptoms, rash, headache, blindness, seizures, the sensation of tingling or creeping on the skin, inflammation of the eye, skin rash, and mild liver damage. Higher doses can cause significant nausea. Death to brain tissue is also a possibility. In higher doses the side effects may include conjunctivitis (inflammation of the white lining of the eye), which may be relieved by eye drops; skin rash, and elevation of certain liver function blood tests. Loss of coordination may occur; it is usually mild and temporary,, but on rare occasions can be severe and permanent. Shortness of breath, with fluid in the lungs and enlargement of the heart or inflammation of the tissue surrounding the heart have also rarely occurred.

Cisplatin may cause high-pitch hearing loss and the loss of certain trace metals from the blood (these trace metals may need to be replaced through medication that can be given by mouth). Cisplatin can also cause kidney damage that can be lessened by adequate fluid intake. In rare instances, cisplatin can cause a life threatening allergic reaction (drop in blood pressure, wheezing, rapid heartbeats and/or facial fullness) within a few minutes of starting the drug.

3. I am aware that, in addition to the risks specifically described above, there are other risks that are present with respect to any treatment.
4. I understand that during the course of this treatment, unforeseen conditions may arise which could require the nature of my treatment to be altered.
5. It has been explained to me that there may be circumstances when information must be disclosed or reported pursuant to law, such as if it is determined during the course of the treatment that I have tuberculosis, viral meningitis, or other diseases required to be reported to state and/or federal authorities such as the Pennsylvania Department of Health or Centers for Disease Control and Prevention.
6. I understand the goals and anticipated benefits of the proposed treatment and the likelihood of achieving those goals. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment.
7. I acknowledge that the information I have received, as summarized on this form, is sufficient for me to consent to and authorize the treatment described above. I have had the opportunity to ask questions concerning my condition, and about the treatment, alternatives and risks, and all questions have been answered to my satisfaction.
8. I impose the following limitation(s) regarding my treatment (if none, so state):

9. I authorize the staff of Penn State Milton S. Hershey Medical Center to preserve for scientific or teaching purposes any tissues or parts which may be removed in the course of this treatment, and to dispose of them.



10. I authorize Penn State Milton S. Hershey Medical Center to permit other persons to observe the treatment with the understanding that such observation is for the purpose of advancing medical knowledge.
11. I certify that all blanks requiring insertion of information were completed before I signed this consent form.

_____ provided the information summarized above and obtained
(fill in name) the consent for the procedure

_____/_____/_____
(Patient's Signature) (Date) (Time)
(or signature of person consenting on behalf of the patient)

_____/_____/_____
(Optional: Witness to Patient's Signature) (Date) (Time)

_____/_____/_____
(Physician's Signature) (Printed name) (Date) (Time)

