PENNSTATE HERSHEY
Cancer Institute
1855

Revised: 11/2015

Consent for Chemotherapy/Biotherapy, **CHOP**

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:

   Cyclophosphamide Doxorubicin Vincristine Prednisone

   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 problems from my cancer.
   provider initials

2. My physician has discussed with me the items that are briefly summarized below:

   a. 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.

   b. **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:

Cyclophosphamide: There is a small chance of causing urinary bladder (where urine is stored) irritation. This bladder irritation can cause pain and the appearance of blood in urine. However, this is almost always avoidable by drinking 8 to 10 glasses of water a day and emptying my bladder every 2 to 3 hours for 3 days, especially before bedtime. A metallic taste in the mouth and nasal congestion are commonly experienced immediately after the administration of the drug. Rarely, prolonged administration of the drug has been reported to cause scarring of the lungs which could cause me to experience coughing spells and shortness of breath and may not be reversible. Rarely, there may be severe or life-threatening allergic reactions.

Doxorubicin may cause heart damage when used for prolonged periods of time or in high doses. Due to the red color of doxorubicin, my urine may turn red for 1 to 2 days after I am given the drug; but this is harmless. Also seen is darkening of the nail beds and skin. In rare cases, the fingernails can become loose.

Vincristine may cause constipation, urinary retention (difficulty urinating), nerve damage (numbness in the fingers or toes) which may be severe and permanent, unstable gait, loss of deep tendon reflexes, muscle aches, temporary blindness (rare), seizures, pain in the jaw, temporary salt and fluid imbalance, fever and rarely inflammation of the pancreas.

Prednisone may cause an irritation of the stomach lining (possibly leading to an ulcer which can bleed), high blood pressure, high blood sugar (or the aggravation of existing diabetes), serious infections and delayed wound healing, elevated white blood count, decrease in blood sodium, increased appetite, weight gain, rash, skin thinning, facial hair growth, acne, facial redness, bruises, menstrual changes, difficulty sleeping, muscle weakness, wasting, mood changes, seizures, fluid retention and swelling, cataracts, increased pressure behind the eye and bone weakening.

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.

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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 the consent for the procedure
(fill in name)

_____/_____/_____
(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)

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