

I, _____ (patient name), understand that I have been diagnosed with
_____. My physician, _____,

has recommended the following treatment(s): ☐ Chemotherapy ☐ Immunotherapy ☐ Biotherapy

Medication(s): _____

Possible side effects may include any or a combination of the following:

- | | | | |
|--|--|---------------------------------------|-------------------------------------|
| • Allergic and allergic-like reactions | • Fatigue | • Loss of appetite | • Numbness or tingling |
| • Anemia | • Forgetfulness | • Low platelet count causing bleeding | • Rectal sores |
| • Blood clots | • Hair loss | • Low white blood cell count | • Risk of infection |
| • Bone pain | • Hearing loss | • Lung damage | • Secondary cancer |
| • Cognitive impairments | • Heart damage | • Menopausal symptoms | • Skin and nail darkening |
| • Constipation | • Inflammation of body systems | • Menstrual irregularities | • Skin rash |
| • Diarrhea | • Kidney damage | • Mouth sores | • Skin ulceration at injection site |
| • Dizziness | • Light and/or temperature sensitivity | • Muscle aches/weakness | • Sterility |
| • Electrolyte imbalance | • Liver damage | • Nausea or vomiting | • Thyroid changes |
| • Erectile dysfunction | | | • Weight gain or loss |

Unexpected side effects may occur in addition to those noted above. Cancer treatment can cause long-term toxicities. In rare instances, cancer treatment can cause life-threatening complications and death.

Please initial each statement below.

- _____ I understand treatment carries the risk of complications, including any unforeseen event, injury, disability, and death. No guarantee is made as to the result or cure. My physician has told me of possible benefits, risks, or side effects of the treatment, including possible problems that might occur during treatment and recovery.
- _____ My physician has explained to me the goal of my treatment: ☐ Palliative/Disease control ☐ Curative intent
- _____ My physician has told me of reasonable alternatives and the possible risks, benefits, and side effects related to alternatives, including the possible outcome of not receiving care or treatment.
- _____ I understand that an FDA approved biosimilar medication may be used. Biosimilars are FDA-approved biologic medications that are compared to another medication — the original biologic.
- _____ I have had the opportunity to ask my physician any questions I have about this treatment and my questions have been answered to my satisfaction. I understand I can contact my physician at any time if I have more questions.
- _____ I understand there is potential risk to the fetus if I become pregnant during treatment. Chemotherapy may interfere with my fertility and render me infertile.
- _____ I agree to use contraception during chemotherapy.
- _____ I understand I can stop treatment at any time.



Consent/Refusal/
Request/Release

OTS Patient Informed Consent
Adventist Health Tillamook
1000 Third St., Tillamook OR 97141

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My signature on this form indicates that I have read and understand the information provided in this form; I have received all the information I need concerning the treatment; and I authorize and consent to undergo the treatment.

Signature: _____ Date: _____

Print name: _____ Time: _____ am/pm

If signed by other than patient, indicate relationship: _____

Witness: _____ Date: _____

Print name: _____ Time: _____ am/pm

Physician documentation of informed consent. I, the undersigned physician, hereby certify that I have discussed the treatment with this patient or other legally responsible person, including the risks and benefits of the treatment, any adverse reactions that may reasonably be expected to occur, any alternative efficacious methods of treatment which may be medically viable, and any research or economic interest I may have regarding this treatment. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Physician signature

Date

Time

Physician printed name

Interpreter's statement. Interpretation services of the foregoing document have been provided to:

_____ in their primary or preferred language (identify language): _____

☐ Interpreter services have been declined and the following person has been requested as interpreter by the patient or patient's legal representative:

Name _____ Relationship: _____

— OR —

☐ Name/ID# of interpreter or language line operator:

Staff signature: _____ Date: _____ Time: _____



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