NAME

ADDRESS

CHI

You have been advised to receive a course of SACT (systemic anti-cancer therapy)

Name(s) of SACT drugs _____

Aim(s) of treatment _____
(non-medical terminology)

Planned duration of treatment _____

Name of consultant making treatment decision _____

Part A – to be completed by the patient / parent / guardian (delete as appropriate)

1. I have had a discussion with my doctor who has explained the goals and anticipated benefits of my treatment
2. I have had a discussion about what alternative treatment options are available to me
3. I acknowledge that no guarantees have been given about the outcome of my planned cancer treatment
4. I understand that the recommended treatment can have short-term and long-term side effects
5. I understand that each patient may respond differently to treatment. I may experience side-effects which have been listed in the written information given to me during the discussion. I may have some side effects about which I have not been warned because they are rare or have not yet been reported by other patients
6. I understand that in a small number of cases the complications from the treatment itself can be life-threatening
7. I have been given written information to support the information given to me in my consultation which I have been advised to read prior to starting my treatment ☐ Macmillan ☐ Local ☐ Other _____ Should I require further explanation or advice I will contact a member of the team
8. I have been given information about what to do and who to contact if I get side-effects or problems with treatment: Chemotherapy booklet ☐ Alert card ☐ Purple leaflet (haem) ☐ Other _____
9. I have understood and accept the possible side-effects of this cancer treatment
10. I have been advised to talk to members of staff if I develop any concerns about the treatment or its side-effects in the future
11. I have discussed with my doctor any issues of particular importance to me with regard to treatment (please write details here)

    _____

    _____
12. I understand that the treatment will be prescribed and supervised by a consultant or other appropriately trained members of the team
13. I have been advised to inform staff of any changes to any medicines that I am taking including over-the-counter or complementary medicines

NAME

ADDRESS

CHI

14. I understand that staff can access my electronic care summary to help ensure safe prescribing of treatment, and I agree to this

15. I understand that some of my treatment information may be used locally or nationally in order to collect data and improve standards

16. **Male patients:**
    - I understand that I should not father children during this treatment or for at least 6 months after it finishes as SACT may be very harmful to unborn babies

17. **Female patients of childbearing potential:**
    - I confirm that to the best of my knowledge I am not pregnant and that I will inform a member of staff if at any stage during my treatment there is a possibility that I might become pregnant
    - I understand that I should not become pregnant while undergoing SACT or for at least a year after completing this treatment. I understand that SACT may be very harmful to unborn babies

18. I have had enough time to consider my options and make a decision about treatment

19. I agree to the advised treatment, which has been explained to me by the doctor named below

20. I understand that I may stop this treatment at any time and I will contact my consultant if I wish to do so

21. I will receive a copy of this consent form

Signature of patient/ parent/ guardian_____ Date _____

Relationship to patient (if not patient) _____

Part B – to be completed by the interpreter (where appropriate)

1. I have interpreted the information above to the patient to the best of my ability and in a way in which I believe s/he can understand

Signature of interpreter _____ Date _____

Name of interpreter _____

Part C – to be completed by the consultant / delegated deputy

1. I confirm that I have explained the treatment advised, described the potential side effects, and provided appropriate written information to the patient and/or to one of the parents or guardians of the patient

2. I will provide a copy of the signed consent form to the patient

Doctors signature_____ Date _____

Name of doctor_____ Designation _____

PATIENT SHOULD RECEIVE A SIGNED COPY TO TAKE HOME. ONE COPY STAYS IN THE PATIENT RECORD