

Space for Medical Institution Name and Logo

2003 יוני /OONCO/TRT/CHM/0014 ט

טופס הסכמה : טיפול כימי

CONSENT FORM: CHEMOTHERAPY

The purpose of chemotherapy is to damage and destroy the tumor cells. Chemotherapy is used for treating the disease or preventing recurrence, depending on the situation. Medications are administered orally, and/or by injection, and/or by intravenous/intra-arterial infusion, and/or by injection into body cavities/target organs, and/or by injection into the spinal canal. The drug dosage is patient-specific, and usually determined according to the patient's height and weight, taking into consideration any other illnesses and the patient's tolerability. The duration of the treatment is determined by a pre-defined plan, or according to the patient's reaction.

Name of Patient: _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:

Dr. _____
Last Name First Name

concerning my malignant disease and its treatment, including a recommendation for chemotherapy:
_____ (henceforth: "the primary treatment").

I have been told that several side effects of chemotherapy drugs are currently known:

1. The drugs may cause nausea, vomiting and diarrhea. Medications are available to vastly reduce or even completely prevent these side effects.
2. Various drugs may cause partial or complete loss of hair. This side effect is usually reversible.
3. The white blood cells, red blood cells and platelets are often damaged, and their number is temporarily reduced. A decrease in the number of red blood cells (anemia) may cause weakness, fatigue and palpitations. This condition can be treated with transfusion of blood units or medicinal means. A decrease in the number of platelets may, in extreme cases, cause bleeding that can manifest as the appearance of red urine, or various spots on the skin. Any hemorrhage requires immediate referral for treatment. A decrease in the number of white blood cells may reduce the body's resistance and lead to infections, which may manifest as a fever or generalized systemic deterioration. An infection that occurs as a result of injection of drugs into the spinal canal may be lethal. It was made clear that I must immediately notify the attending staff of any fever of 38 degrees or higher, or refer to the emergency room. Any indication of infection will, in most cases, require oral or intravenous antibiotic treatment necessitating hospitalization.
4. Some chemotherapy drugs may cause ulcers or sores on the tongue or other parts involved in swallowing. I am aware that I must immediately notify the attending staff of these so that they may be treated on time.
5. In rare cases, impairment of memory and concentration may occur.
6. Leakage of drugs from the vein may, at times, cause an inflammatory reaction or local necrosis. It was clarified that I must immediately report any pain in the area where the infusion is inserted, in order to enable medicinal treatment.
7. In addition, it was made clear that:



Israel Medical Association

Israeli Association of Clinical Oncology & Radiology
Israeli Association of Hematology & Blood Transfusions
The Israeli Society of Pediatric Hematology & Oncology

Ministry of Health



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- A. Certain drugs have additional special side effects that were not mentioned above, such as: allergic reactions, damage to the heart muscle, lung damage, kidney damage, impairment of hearing, nerve damage, impairment of fertility and various skin disorders. **In children** – delayed growth and development, and retention of fluid.
- B. Chemotherapy injected into the spinal canal may cause brain damage.
- C. There is a rare possibility of the occurrence of a secondary malignancy as a result of the chemotherapy.
- D. Drug combinations may have unique side effects or may enhance other side effects.
- E. In rare cases, the side effects may be particularly severe, and even end in death.
- F. Treatment of the side effects may necessitate hospitalization.

I hereby give my consent to perform the primary treatment.

I know and agree that the treatment and any other procedure will be performed by any designated physician, according to the hospital/center/clinic/unit/department's procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the standard degree of responsibility and in accordance with the law.

Date	Time	Patient Signature
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Name of Guardian (Relationship)	Guardian Signature (for incompetent, minor or mentally ill patients)
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I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician	Physician Signature	License No.
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* Cross out irrelevant option.



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