Tallahassee Cancer Institute

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Consent to Receive Anti-Cancer Therapy

I understand that I have been diagnosed with _____. I am being asked to voluntarily consent and authorize Dr. Amer G. Rassam and associates of **Tallahassee Cancer Institute** to prescribe and administer medications to treat my medical condition. These medications may be administered by vein, by mouth or as a simple injection into the skin. All of these medications are powerful drugs meant to treat difficult diseases. Each of these drugs has potential side effects; this consent acknowledges that my physician has reviewed these with me. My caregivers will provide more specifics regarding the schedule and detailed side effects of the particular drugs that I will receive. I have been informed that anticancer drugs can damage all cells, including normal cells in the body and this is what causes side effects. Some of these complications can prove life threatening and require hospitalization and/or blood transfusions for management. Potential side effects may include but are not limited to, the following:

- Low Blood counts, which may cause tiredness, infection or bleeding
- Nausea, vomiting, loss of appetite
- Mouth sores
- Diarrhea or constipation
- Allergic reaction
- Hair loss
- Decreased kidney, liver or heart function
- Tingling or numb fingers/toes
- Skin rashes and changes in fingernails and toenails
- Future infertility
- Other cancers
- Death

Some of these side effects can be treated with medications. Others may simply improve with the passage of time. Some are irreversible. I understand that all reasonable care will be taken to minimize these side effects.

Whether I am a male or female, treating my disease includes treatment which may present certain or unknown risks to a fetus or embryo. I must avoid becoming pregnant or avoid causing a pregnancy while I am receiving treatment. I should discuss the alternatives available to me for pregnancy prevention with my physician.

By signing this form, I acknowledge that Dr. Amer G. Rassam has explained to me my condition, proposed treatment and the risks related to not receiving the proposed care, treatment and services, any alternative forms of treatment (including risks, benefits and side effects), the risks and possible complications in the proposed treatment plan. Additionally, I acknowledge that I have been given the chance to ask questions about my medical diagnosis, treatment plan, alternative forms of treatment, and side effects of treatment. The option of not receiving treatment has also been discussed. I understand that I am free to withdraw my consent and have this form of treatment stopped at any time and continue to receive care from my physicians.

_____ _____
Patient / Legally Responsible Person Signature Date

Witness Signature: _____ Relationship: _____

Consent Obtained by: _____ Title: _____