

PATIENT CONSENT FORM FOR INFUSION SERVICES

I, _____, the undersigned, hereby authorize Cascade Cancer Center and Dr. _____ to administer the following treatment(s):

I have reviewed the purpose of these medicine(s) with my ordering physician. I have received descriptions of my medicines and the overall treatment plan. I have received an explanation of how the medications are given, as well as any possible side effects. I accept the treatment program and method of medication administration proposed to me as one of the medically acceptable means of treatment.

I recognize that some of the medications may cause damage to my veins and the surrounding tissues, causing changes in their appearance, even when the medication is given properly. Some of the medications may cause drowsiness and may impair my ability to drive or operate equipment. I understand that if I receive a medicine that may cause drowsiness, I am required to have someone drive me home after those treatments.

Adverse reactions to the medicines, if serious, could result in permanent injury or even death. In the event of physical injury, adverse reactions or side effects resulting from these medications, medical treatment will be provided. The cost of treatment and hospitalization of such adverse reactions or side effects, however, will be my responsibility. I am aware that some agents may result in early menopause. These agents may also cause infertility in both men and women and may be teratogenic and/or lethal to a developing fetus.

My ordering physician has given me a contact number in case of an emergency.

In signing this form, I indicate that: 1) I understand the medications being administered and the methods by which they will be given to me; 2) I understand the potential risks and hazards involved in the treatment that my doctor has chosen.

I understand that I have the right to refuse treatment, and that I have the right to refuse to continue treatment after it has begun.

I acknowledge receipt of this consent form. My signature indicates that I have read and understand this form, and that I wish to proceed with the treatment proposed.

Patient Signature (or person authorized to consent for the patient)

Date

Signature of Ordering Physician

Signature of Person Verifying Consent

Revised 9/2007