



Consent for Chemotherapy and Infusion Therapy

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

1. Purpose of Treatment

I understand that I have been diagnosed with:

Prescribed Treatment:

My doctor has recommended chemotherapy and/or infusion therapy as part of my treatment plan. The goal of this treatment may be to cure my disease, control its progression, reduce symptoms, or improve my quality of life.

2. Description of Treatment

Chemotherapy/infusion therapy involves the administration of medications through a vein, under the skin, or by other routes. These medications may include:

- Chemotherapy drugs
- Targeted therapy
- Immunotherapy
- Supportive medications (such as anti-nausea medicines, hydration, or blood products)

3. Potential Benefits

- Control or shrink tumor growth
- Relieve or prevent symptoms caused by my illness
- Improve quality of life and/or extend survival

4. Possible Risks and Side Effects

I understand that all medical treatments carry risks. Possible side effects include, but are not limited to:

- Common: Nausea, vomiting, diarrhea, fatigue, hair loss, appetite changes, mouth sores, skin/nail changes
- Blood-related: Low blood counts, anemia, increased risk of infection, easy bruising or bleeding
- Organ-related: Liver, kidney, heart, nerve, or lung effects
- Allergic or infusion reactions: Rash, itching, fever, chills, difficulty breathing, low blood pressure
- Serious risks: Infertility, secondary cancers, life-threatening complications, or death

I understand that side effects vary among patients and cannot be fully predicted.

5. Alternatives

I have been informed of alternatives to chemotherapy/infusion therapy, which may include:

- Surgery
- Radiation therapy
- Oral medications
- Supportive/palliative care only

I understand that I may refuse treatment at any time without losing access to supportive care.

6. Patient Rights

- I may withdraw my consent at any time.
- I have the right to ask questions and receive clear answers.
- I understand that additional medications, blood transfusions, or hospital admission may be needed if complications occur.
- I will immediately inform my healthcare team if I experience unusual symptoms or reactions.

7. Consent Statement

I have read (or had read to me) and understand the information in this consent form. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

I voluntarily consent to receive chemotherapy and/or infusion therapy as recommended by my doctor.

Patient (or Legal Representative) Signature: _____

Date: _____

Printed Name of Legal Representative (if applicable): _____

Relationship to Patient: _____

Physician/Provider Signature: _____

Date: _____

Witness (if required): _____

Date: _____