Patient agreement to systemic anti-cancer therapy (SACT)

Cisplatin + Radiotherapy

Hospital/NHS Trust/NHS Board:

_____

_____

Responsible consultant:

Name: _____

Job title: _____

Patient details

Patient's surname/family name:

_____

Patient's first name(s): _____

_____

Date of birth: _____

NHS number: _____
(or other identifier)

Special requirements:
(eg other language/other communication method)

_____

_____

_____

_____

Name of proposed course of treatment (include brief explanation if medical term not clear)

☐ Cisplatin chemotherapy in combination with radiotherapy for the treatment of head and neck cancer. Treatment will start with radiotherapy. A separate consent from must be completed for radiotherapy.

☐ Given intravenously on day 1, every 7 days for 6 to 7 weeks OR

☐ Given intravenously on day 1, every 21 days for 2 to 3 cycles OR

☐ Given intravenously on day 1, every 28 days for 2 cycles.

Where will I have treatment?

☐ Outpatient ☐ Day unit/case ☐ Inpatient ☐ Other: _____

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in the hospital/Trust/NHS board's consent policy)

☑ Tick all relevant boxes

☐ I confirm the patient has capacity to give consent.

☐ I have explained the course of treatment and intended benefit to the patient.

The intended benefits (there are no guarantees about outcome)

☐ Curative – to give you the best possible chance of being cured.

☐ Disease control or palliative – the aim is not to cure, but to control or shrink the disease and improve both quality of life and survival.

☐ Adjuvant – therapy given after surgery or radiotherapy to reduce the risk of the cancer coming back.

☐ Neo-adjuvant – therapy given before surgery or radiotherapy to shrink the cancer, allow treatment and reduce the risk of the cancer coming back

Statement of health professional

Patient identifier/label

You may have one or more of the side effects listed

Common side effects:

Affecting more than 10 in every 100 (>10%) people

- ☐ An increased risk of getting an infection from a drop in white blood cells - it is harder to fight infections and you can become very ill.
- ☐ If you have a severe infection this can be life-threatening. Contact your doctor or hospital straight away if:
  - **your temperature goes over 37.5°C or over 38°C, depending on the advice given by your chemotherapy team**
  - **you suddenly feel unwell (even with a normal temperature)**
- ☐ Ear problems (ringing in the ears, changes in hearing and uncommonly high frequency hearing loss which may be permanent), numbness or tingling in hands and feet (which may be temporary or permanent), changes in kidney function which is monitored.
- ☐ Loss of appetite, change in taste, feeling sick (nausea), being sick (vomiting), diarrhoea.
- ☐ Anaemia (due to low red blood cells), bruising or bleeding (due to low platelets), low sodium and high uric acid levels in the blood (e.g. gout).

Occasional side effects:

Affecting between 1-10 in every 100 (1-10%) people

- ☐ Thinning of the hair or hair loss, changes in heart rhythm, low or high heart rate.

Other risks:

- ☐ Cisplatin may leak out of the vein while it is being given (extravasation) and can damage the tissue around the vein. Tell the nurse straight away if you have any stinging, pain, redness or swelling around the vein. It's uncommon but important to deal with quickly.
- ☐ Side effects of radiotherapy may be temporarily increased when given alongside chemotherapy.
- ☐ Allergic reactions while having cisplatin is not common.
- ☐ Potential side effects with the anti-sickness medication may include: constipation, headaches, indigestion, difficulty sleeping and agitation.
- ☐ Steroids can raise your blood sugar. If you have diabetes, it may lead to higher blood sugar levels. Please ask your doctor/nurse/GP if concerned.
- ☐ Cancer and treatment for cancer can increase your risk of developing a blood clot (thrombosis). A blood clot may cause pain, redness and swelling in a leg, or breathlessness and chest pain or stroke. Tell your doctor straight away if you have any of these symptoms.
- ☐ Some anti-cancer medicines can damage women's ovaries and men's sperm. This may lead to infertility in men and women and/or early menopause in women.
- ☐ Some anti-cancer medicines may damage the development of a baby in the womb. It is important not to become pregnant or father a child during treatment or for up to 6 months afterwards. Use effective contraception during this time. You can talk to your doctor or nurse about this.
- ☐ Complications of treatment can very occasionally be life-threatening and may result in death. The risks are different for every individual. Potentially life threatening complications include those listed on this form, but, other, exceedingly rare side effects may also be life-threatening.

Statement of health professional

Patient identifier/label

Any other risks and information:

_____

_____

☐ I have discussed the intended benefit and risks of the recommended treatment, and of any available alternative treatments (including no treatment).

☐ I have discussed the side effects of the recommended treatment, which could affect the patient straight away or in the future, and that there may be some side effects not listed because they are rare or have not yet been reported. Each patient may experience side effects differently.

☐ I have discussed what the treatment is likely to involve (including inpatient/outpatient treatment, timing of the treatment, blood and any additional tests, follow-up appointments etc) and location.

☐ I have explained to the patient, that they have the right to stop this treatment at any time and should contact the responsible consultant or team if they wish to do so.

☐ I have discussed concerns of particular importance to the patient in regard to treatment

(please write details here): _____

_____

Clinical management guideline/Protocol compliant (please tick):

☐ Yes ☐ No ☐ Not available If No please document reason here:

_____

The following written information has been provided:

☐ Information leaflet for Cisplatin

☐ 24 hour alert card or SACT advice service contact details

☐ SACT treatment record (cruk.org/treatment-record)

☐ Other, please state: _____

_____

Health professional details:

Signed: _____

Date: _____

Name (PRINT): _____

_____

Job title: _____

_____

Statement of interpreter **(where appropriate)**

Interpreter booking reference (if applicable):

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

Signed: _____ Date: _____

Name (PRINT): _____ Job title: _____

Statement of patient

Patient identifier/label

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy of the form which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

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

☐ I agree to the course of treatment described on this form.

A witness should sign below if the patient is unable to sign but has indicated their consent. A person with parental responsibility will be asked to sign for young people under the age of 16 years.

Patient's signature: _____

Name (PRINT): _____ Date: _____

Person with parental responsibility/witness' signature: _____

Name (PRINT): _____ Date: _____

Copy accepted by patient: yes / no (please circle)

Confirmation of consent

(health professional to complete when the patient attends for treatment, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed that the patient has no further questions and wishes the course of treatment/procedures to go ahead.

Signed: _____

Date: _____

Name (PRINT): _____

Job title: _____

Important notes: (tick if applicable)

☐ See also advance decision to refuse treatment

☐ Patient has withdrawn consent (ask patient to sign and date here)

Signed: _____

Date: _____

Further information for patients

Contact details (if patient wishes to discuss options later):

_____

Contact your hospital team if you have any questions about cancer and its treatment.

Cancer Research UK can also help answer your questions about cancer and treatment. If you want to talk in confidence, call our information nurses on freephone 0808 800 4040, Monday to Friday, 9am to 5pm. Alternatively visit cruk.org for more information.

These forms have been produced by Guy's and St. Thomas' NHS Foundation Trust as part of a national project to support clinicians in ensuring all patients are fully informed when consenting to SACT.

The project is supported by Cancer Research UK. This does not mean you are taking part in a clinical trial.