Patient agreement to systemic anti-cancer therapy (SACT)

Fedratinib

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)

☐ Fedratinib for the treatment of myeloproliferative neoplasms (MPN).

☐ Fedratinib is taken orally once daily. Treatment is supplied every 28 days (one cycle).

☐ Treatment is continued until disease progression, unacceptable side effects or withdrawal of consent.

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)

☐ To prevent or reduce the risk of thrombosis (blood clots) and/or bleeding.

☐ To reduce spleen size.

☐ To control blood counts.

☐ To control symptoms.

Patient identifier/label

Statement of health professional

You may have one or more of the side effects listed

Common side effects:

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

- ☐ Anaemia which may cause tiredness, shortness of breath, pale skin (due to low red blood cells), bruising or bleeding (due to low platelets), low white blood cells (which may increase your risk of infections).
- ☐ Feeling sick (nausea), being sick (vomiting), diarrhoea, constipation.
- ☐ Headache, tiredness (fatigue) or feeling weak (fatigue), muscle spasms.
- ☐ Changes in liver and kidney function.This will be monitored but may be a sign of liver, kidney or pancreas problems
- ☐ Urinary tract infection.

Occasional side effects:

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

- ☐ Dizziness, increase in blood pressure.
- ☐ Bone pain, pain in the hands or feet.
- ☐ Pain when passing urine.
- ☐ Indigestion, weight gain.
- ☐ Inform your doctor straight away of you experience confusion, memory loss, difficulty thinking and/or walking, loss of balance or eye problems (loss of vision/double vision/blurred vision/random eye movements). This can be a sign of a serious condition which affects the brain called encephalopathy (including Wernicke's encephalopathy).
- ☐ Fedratinib can reduce thiamine levels in your body which can cause Wernicke's encephalopathy. This can be life-threatening and is due to deficiency of thiamine (vitamin B1). You may be given thiamine supplementation. If your thiamine levels are low, you will require urgent thiamine supplementation.

Other risks:

- ☐ Increased risk of skin cancers which can be aggressive. Protect your skin from sun exposure and check your skin for any changes in appearance, new growths or lesions (that may look like a new wart), or change in the size or colour of a mole. Let your haematology team know if you're worried about any new/enlarging skin growths or lesions.

Other risks continued:

- ☐ Before treatment, you might have blood tests to check for viruses such as Hepatitis B, Hepatitis C, HIV or more unusual infections. This treatment may weaken your natural defence (immune) system, so infections like this could worsen or become active again if you've had them in the past. You may have medicines to prevent or treat infection. Please make sure you have received all vaccinations recommended for you.
- ☐ Do not stop taking fedratinib unless your doctor has told you to. Suddenly stopping may cause symptoms of your myeloproliferative neoplasm to come back. This can be severe or life-threatening if not stopped slowly.
- ☐ Cancer and its treatment can increase your risk of developing a blood clot (thrombosis), causing pain, redness and swelling in an arm or leg, breathlessness, chest pain or stroke. Tell your doctor straight away if you have any symptoms.
- ☐ You may notice changes in your memory, concentration, or your ability to think clearly. There can be many causes of this including your treatment, diagnosis, or both.
- ☐ Some anti-cancer medicines can damage ovaries and sperm. This may lead to infertility and/or early menopause.
- ☐ Some anti-cancer medicines may damage the development of a baby in the womb. It is important not to become pregnant or make someone else pregnant during treatment and for several months after. Use effective contraception throughout. Speak to your doctor or nurse, if you have questions 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.

Patient identifier/label

Statement of health professional

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 Fedratinib

☐ 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.

Guidance for health professionals

(to be read in conjunction with the hospital's consent policy)

Patient identifier/label

What a consent form is for

This form documents the patient's agreement to go ahead with the treatment you have proposed. It is not a legal waiver – if patients, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. Patients are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoir to health professionals and patients, by providing a checklist of the kind of information patients should be offered, and by enabling the patient to have a written record of the main points discussed. In no way should the written information provided for the patient be regarded as a substitute for face-to-face discussions with the patient.

The law on consent

See the following publications for a comprehensive summary of the law on consent. Consent: Patients and doctors making decisions together, GMC 2020 (gmc-uk.org/guidance). Reference guide to consent for examination or treatment, Department of Health, 2nd edition 2009 (doh.gov.uk).

Who can give consent

Everyone aged 16 or over is presumed to have the capacity to give consent for themselves, unless the opposite is demonstrated. For young people, it is good practice to involve those with parental responsibility in the consent discussions, unless specifically asked not to. A person with parental responsibility must sign this form for a child or young person under the age of 16. Such patients should be given the opportunity to 'assent' to treatment if they wish. If a patient has the capacity to give consent but is physically unable to sign a form, you should complete this form as usual and ask an independent witness to confirm that the patient has given consent orally or non-verbally.

When NOT to use this form

If the patient lacks the capacity to give consent, you should use an alternative form available for this purpose (dependent on patient age). A patient lacks capacity if they have an impairment or disturbance of the brain, affecting the way their mind works. For example, if they cannot do one of the following:

- understand information about the decision to be made
- retain that information in their mind
- use or weigh this information as a part of their decision making process, or
- communicate their decision (by talking, using sign language or any other means)

You should always take all reasonable steps (for example involving more specialist colleagues) to support a patient in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign a form on behalf of an adult who lacks capacity to consent for themselves, unless they have been given the authority to do so under a Lasting Power of Attorney or as a court deputy.

Information

Information about what the treatment will involve, its benefits and risks (including side-effects and complications) and alternatives to the particular procedure proposed, is crucial for patients when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'significant, unavoidable or frequently occurring' risks. If patients make clear they have particular concerns about certain kinds of risk, you should ensure that they are informed about these risks, even if very small or rare. You should always answer questions honestly. Sometimes, patients may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that the patient receives at least very basic information about what is proposed. Where information is refused, you should document this on the consent form or in the patient's notes.

NHS Scotland

NHS Scotland staff should refer to Healthcare Improvement Scotland. Guidance on consent for SACT and local NHS Board guidance on consent aligned to the Scottish legal framework.

References

1. Summary of Product Characteristics for individual drugs: medicines.org.uk/emc
2. Cancer Research UK: cruk.org/about-cancer/treatment/drugs
3. Macmillan Cancer Support: macmillan.org.uk/cancer-information-and-support/treatments-and-drugs
4. Guy's and St. Thomas' NHS Foundation Trust, Chemotherapy consent form