| | INFORMATION AND CONSENT FORM CHEMOTHERAPY | | | |
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| Doc. № | Date of issue | Revision № | Revision date | Number of pages |
| HD.RB.198 | October-2018 | 01 | October-2020 | 1/2 |

**Patient's name and surname:** **Sex:**
**Date of birth:** **Date of hospitalization:**
**Dagnosis:** **Protocol №:**

Because of your illness you need to take chemotherapy. Chemotherapy is a treatment used to kill the tumour cells which are the main reason of your illness. These medication is given mostly with a serum intravenously or you swallow pills. Using chemotherapy we aim for controlling the tumour, to stop the expending of the illness, to regress the illness and to improve your life quality. But in some cases these positive effects may not happen, then your doctor will talk to you about changing the treatment. He may change the chemotherapy medicine or he may give you other medicines called support treatment. Every 21 days there is a chemotherapy protocol and this is called a cure. The chemotherapy treatment lasts for 4 to 6 cures according to the condition of the patient. After the chemotherapy cures are completed, if your illness repeats while you are under observation, the same or different chemotherapy medications can be applied.

The medications which are used in chemotherapy may have some side effects, as they effect not only tumour cell but also normal healthy cells. That is why some side effects may occur. These side effects may threaten your life. These side effects relating chemotherapy medications can be seen in early, mid (2 weeks) and later period.

The side effects occurring in early period can be allergic reactions, pain, redness on the entrance of the needle, sickness and vomiting, red colour of urine and sensibility to light.

Side effect occurring in 2 weeks can be low blood level (leucocytes, erythrocyte, thrombocytes). Low leucocytes (white blood cells) can cause infections, low erythrocytes (red blood cells) can cause exhaustion, low thrombocytes (coagulation cells) can cause bleeding. And also inappetence, disorder in tasting, constipation and diarrhoea, mouth lesions, fatigue, hair loss can occur.

In later period hormonal effect (differences in periods), lung side effects (dry cough, breathing disability), also complications related to kidneys and death risk can occur.

The level of side effects can chance depending on the patient, the medications used and the amount of chemotherapy cures the patient gets. We will take all the medical precautions and surveys to reduce side effects. We will observe all organs which may possibly be effected by chemotherapy, and if they get effected we will treat them.

Me,_____ I have read the information above / my companion read and understood. My doctor told me the risks I will face and the progression of my illness. Besides he told me the chemotherapy treatment may not be successful. I have learned the benefits and side effect of chemotherapy for my illness. I have had a satisfying and enlightening conversation with my doctor. I have had clear answers for all my questions. I understood what they told me.

I was given enough time to decide whether I was going to take chemotherapy or not. I give my consent with my free will for the chemotherapy treatment and for any decision that oncologists will have to take.

I was told this treatment may not be successful.

All the gaps were filled in before signed.

Remarks :

1.If the patient is younger than 18, unconscious or cannot sign, the approval should be given by the parent, guardian or a family member.

Please write with your handwriting "I give my consent"

Estimated time of process:.....

Please write: "I've read and understood this information on my health disorder and the treatment course, and I give my consent"

**THE PATIENT'S NAME-SURNAME:**
……

**TIME AND DATE:**
……

**SIGNATURE:**
……

**TRANSLATOR'S NAME-SURNAME:**
……

**TIME AND DATE:**
……

**SIGNATURE:**
……

**PATIENT RELATIVE'S NAME-SURNAME:**
……

**TIME AND DATE:**
……

**SIGNATURE:**
……

**WITNESS'S NAME-SURNAME:**
……

**TIME AND DATE:**
……

**SIGNATURE:**
……

I have clearly explained the information in this Consent Form to the patient, his/her parents, relatives or companions.

**THE DOCTOR'S NAME-SURNAME:**

**TIME AND DATE:**

**SIGNATURE:**



| HAZIRLAYAN | KONTROL EDEN | YÜRÜRLÜK ONAYI |
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