PENNSTATE HERSHEY
Cancer Institute

Consent For IMMUNOTHERAPY (Adjuvant Interferon Alfa-2B
Condition For Which Treatment is Proposed:_____

1. I hereby authorize my physician, Dr_____, and/or such other staff physicians or resident physicians as my physician may designate, to administer to me (or the patient for whom I consent) the following immunotherapy consisting of:

Adjuvant Interferon Alfa-2B

The plan for my course of immunotherapy is for _____cycles of Adjuvant Interferon

Alfa-2B, with each cycle given about every _____days.

2. My physician has discussed with me the items that are briefly summarized below:

   a. The nature and purpose of the proposed therapy is to administer immunotherapy (drugs to fight my cancer, which may also have other effects on my body) by mouth and/or by vein or by other type of injection.

   b. The risks of the proposed immunotherapy:

Immunotherapy may cause nausea, vomiting, loss of appetite, mouth sores, hair loss, fatigue, a lowering of the white blood cell count (which can lead to a serious infections), a lowered platelet count (which can lead to bleeding), and a decrease in my red blood cell count (which can lead to shortness of breath, a rapid heart beat or weakness). Due to these low blood counts, I may require red blood cell or platelet transfusions. My doctor will give me appropriate medications to try to decrease the severity of any side effects. Other side effects could occur, rarely death. It is important that I call my physician or nurse-coordinator with problems which occur during the course of my treatment. I always have the right to refuse immunotherapy at any time. It is possible that this immunotherapy may not be effective and my disease might progress.

Long-term side effects of immunotherapy can include injury to lungs, heart, liver and/or bladder.

Immunotherapy usually has an adverse effect on sperm and eggs and can cause me to be unable to have children. Immunotherapy can have harmful effects on an unborn child. If I am a woman, it is important to tell my physician if I think I may be pregnant. It is possible to conceive a child during treatment with immunotherapy. It is important that both men and women who are being treated with immunotherapy and who are sexually active, fertile, and who have a fertile partner use a reliable form of birth control (birth control pills, a reliable barrier method or a hormonal implant.

You (or the patient for whom you consent) may require **venipuncture** (putting a needle into a vein to remove blood or administer immunotherapy). The discomfort associated with venipuncture is a slight pinch or pinprick when the sterile needle enters the skin. The risks of venipuncture include mild discomfort and/or a black or blue mark at the site of the needle puncture. Less commonly, a small blood clot, infection or bleeding may occur at the needle puncture site. When immunotherapy is administered into a vein, there is also a small risk of either infection in the bloodstream or the immunotherapy leaking outside the vein causing tissue irritation or damage.

The drugs, which will be used for my planned immunotherapy and their specific side-effects:

Adjuvant Interferon Alfa-2B: Flu-like symptoms, depression, sleeplessness, skin rash, weight loss, changes in taste, patients with a known heart condition may be at risk for serious side effects, and altered liver function tests seen on routine lab work.

3. The medically reasonable alternative treatments and the risks associated with these alternative treatments have been described by my physician. These alternatives include no treatment, combinations of different chemotherapy drugs, or the same drugs given in different doses or on a different schedule.

4. Without the proposed treatment, my disease may progress, it could remain stable or, rarely, improve.

5. I understand that during the course of this immunotherapy, unforeseen conditions may arise which could require the planned immunotherapy to be altered. All alterations to the planned immunotherapy will be discussed with me.

6. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed therapy.

7. I acknowledge that the information I have received, as summarized on this form, is sufficient for me to consent to and authorize the immunotherapy described above. I have had the opportunity to ask questions concerning my condition, the immunotherapy, the alternatives and risks, and all questions have been answered to my satisfaction.

8. I impose the following limitation(s) regarding my treatment (if none, so state):_____
_____

9. I authorize the staff of The Milton S. Hershey Medical Center to preserve for scientific or teaching purposes any tissues or parts which may be removed in the course of this procedure, and to dispose of them.

10. I authorize the Milton S. Hershey Medical Center to permit other persons to observe this therapy with the understanding that such observation is for the purpose of advancing medical knowledge. I authorize The Milton S. Hershey Medical Center to obtain photographic or other pictorial representations of this therapy, and to use such representations for scientific or teaching purposes.

11. I certify that all blanks requiring insertion of information were completed before I signed this consent form.

_____ provided the information summarized above and obtained the consent for the procedure
(fill in name)

_____/_____/_____
(Patient's Signature) (Date) (Time)
(or signature of person consenting on behalf of the patient)

_____/_____/_____
(Optional: Witness to Patient's Signature) (Date) (Time)

_____/_____
(Physician's Signature) (Date)