BRONSON

WMCC
West Michigan Cancer Center
Radiation & Surgical Specialties

Affix Patient Label

WMCC/Bronson HealthCare Group (BHG): Consent for Treatment

Patient Name: _____ Date of Birth: _____

Diagnosis: _____

About this Treatment

My doctor has decided that treatment for my disease will include the following medications.

These medications consist of the drugs named below that are given by these methods:

- ☐ Injection (a shot)

  _____

- ☐ Intravenously (into your vein)

  _____

- ☐ Intraperitoneal (into your abdominal cavity)

  _____

- ☐ Intravesical (within your bladder)

  _____

- ☐ Intrathecal (into the fluid space between the brain/spinal cord)

  _____

- ☐ Orally (by mouth)

  _____

- ☐ Ambulatory pump (battery operated pump you wear at home)

  _____

Goal of this Treatment

My doctor explained the goal of this treatment to be: ☐ Cure or ☐ Non-curative (improving symptoms or prolonging life)

If "**Cure**" is checked, I understand the treatment is an attempt to cure. It is not a guarantee that I will be cured.

If "**Non-curative**" is checked, I understand that the goal of the treatment is to decrease the size or "shrink" the tumor and/or keep the disease under control.

Risks of this Treatment

I understand that I may stop this treatment at any time. I understand how the medications can help me. I understand there are risks and possible side effects related to these medications. I know I can make other treatment choices instead of the medications listed. These treatment options have been fully explained to me. These options include having supportive care only, or supportive care in addition to the medications listed above. I also understand there are benefits, risks and side effects to other treatment choices.

I have had a chance to ask questions about the medications listed and treatment options. I am satisfied with the information provided. I understand I can contact my healthcare provider if I have further questions. I will be given a copy of this consent form.

BRONSON WMCC
West Michigan Cancer Center
Radiation & Surgical Specialties

Affix Patient Label

I authorize West Michigan Cancer Center, the Bronson Healthcare Group and its affiliates, and the health professionals under their supervision to give me this treatment.

I understand that by signing this document I am consenting to receive the proposed treatment.

Patient Signature: _____ Date: _____ Time: _____

Relationship: ☐ Patient ☐ Closest relative (relationship) _____ ☐ Guardian/POA Healthcare

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back:

Patient shows understanding by stating in his or her own words:

_____ Reason(s) for the treatment/procedure: _____
_____ Area(s) of the body that will be affected: _____
_____ Benefit(s) of the procedure: _____
_____ Risk(s) of the procedure: _____
_____ Alternative(s) to the procedure: _____

OR

_____ Patient elects not to proceed: _____ Date: _____ Time: _____
(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____