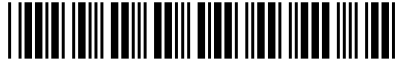

Battle Creek

Cancer Care Center

Affix Patient Label

RADIOACTIVE RA 223 XOFIGO CONSENT

Name: ______________________________________Date of Birth: ________________

This information is to help you make an informed decision about receiving the recommended infusion or injection of **Xofigo**.

Reason and Purpose of the Treatment:
- To treat advanced castration resistant prostate cancer that has spread to the bone.

Benefits of this Treatment:
You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.
- You may or may not receive the following benefits, increased survival and pain control.

Risk of this Treatment:
No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.
- Swelling of the arms or legs
- Low blood cells (white, red and or platelets) you may need a transfusion or medication.
- Nausea
- Diarrhea
- Vomiting

Things to know about this procedure:
- I **must** use condoms and make sure female partners who can have children use highly effective birth control methods during my treatments and for a **minimum of 6 months** after treatment with Xofigo.
- After using a toilet, flush several times. Wash hands thoroughly.
- Caregivers should wear gloves when handling clothing, towels, linens that may have come in contact with bodily fluids.
- Clothing soiled with Xofigo or fecal matter or urine should be washed promptly and separately from other clothing.
- I understand this is a very expensive treatment that is ordered specifically for me. If I fail to keep appointments for treatment I will be responsible for the cost.

Risks specific to you:

____

____

____

Alternative Treatments:
- Other treatment plans.
- No treatment at all.
- Supportive follow up with symptom management.

If you chose not to have this treatment:
- Your symptoms may continue or become severe.

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: ____.

Patient Signature ____

Relationship ☐ Patient/parent of minor ☐Closest Relative/Relationship ☐ Guardian/POA Healthcare

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

________________________________ ________________ ________________

Interpreter (if applicable) *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 __________________________________ (patient signature)

Validated/Witness:______________________________________ Date:_______________ Time: ____________