Consent form
Cancer Directorate (oncology and haematology)
Name and job title:

☐ Any special needs of the patient (eg. help with communication)?

**A** Name of proposed procedure or programme of treatment

(include brief explanation if medical term not clear)  
Patient's side left / right or N/A

**Blood or marrow transplant**

- Autologous transplantation. Conditioning with (specify):
- Allogeneic transplantation. Conditioning with (specify):

**B** Statement of health professional (details of treatment, risks and benefits)

1 I confirm I am a health professional with an **appropriate knowledge of the proposed procedure/treatment**, as specified in the hospital's consent policy. I have explained the procedure/treatment to the patient. In particular, I have explained:

   a) the intended benefits of the procedure/treatment (please state)
   - ☐ Curative – to give you the best possible change of being cured
   - ☐ Palliative – the aim is not to cure, but to control the disease. The aim is to keep you as well as possible for as long as possible.

   b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures/treatments carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient
   - ☐ Transplant related mortality
   - ☐ Bone marrow suppression (including anaemia, infection and bleeding)
   - ☐ Sore mouth and gut side effects
   - ☐ Graft versus host disease
   - ☐ Failure to engraft
   - ☐ Organ toxicity
   - ☐ Late effects (including infertibility and secondary malignancy including myelodysplasia)
   Others including those specific to the patient:

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:

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d) any extra procedures that might become necessary during the procedure/treatment such as:
   - ☐ Blood transfusion
   - ☐ Other procedure (please state, for example anaesthetic)

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The following information leaflet has been provided:

or □ I have offered the patient information about the procedure but this has been declined.

Signed (Health professional): ___________________________ Date: DD/MM/YYYY

Name (PRINT): ___________________________ Time (24hr): H: H: M: M:

Designation: ___________________________ Contact/bleep no: ___________________________

C  Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and that my questions have been answered to my satisfaction and understanding.

An additional information leaflet explaining what consent means is available on request. Please feel free to ask for a copy to read before putting a tick in the relevant boxes for the following questions:

□ Patient has consented to participation of a clinical trial
□ See also advance directive / living will

1 Use of tissue and medical imaging for clinical research
   a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for research which may include genetic research. □ Yes □ No
   b) I agree that relevant sections of my medical record, including medical imaging, may be looked at by researchers, or by relevant regulatory authorities, where my tissue is being used for research. I give permission for these individuals to have access to my records. □ Yes □ No

2 Photography, audio or visual recording
   a) I agree to the use of any of the above type of recordings for the purpose of diagnosis or treatment □ Yes □ No
   b) I agree to unidentified versions of any of the above recordings being used for audit and medical teaching in a healthcare setting. □ Yes □ No

3 Medical Training
I agree to the involvement of medical and other students as part of their formal training. □ Yes □ No

4 Female patients aged 12–55 years. Is there any chance you might be pregnant?
I understand that I need to avoid becoming pregnant during the course of my treatment and, if I think I might be pregnant, I will inform the staff treating me □ Yes □ No

5 Medical Testing
I understand the need for mandatory donor microbiology testing, including HIV, hepatitis B, hepatitis C, HLTv and syphilis screening □ Yes □ No

6 I/We consent to partially anonymised clinical data being shared with regional/national/international data collections including but not limited to the British and the European Blood and Marrow transplant Registries and the International Blood and Marrow Transplant Registry (USA) as appropriate, with the aim of improving patient outcomes. Partially anonymised data is data that cannot identify you as person by the holders of the data collections but the Trust would be able to link this back to the information that it holds about you.

I/We understand that my initials and date of birth will be shared. □ Yes □ No
I have listed below any procedures that **I do not wish to be carried out without further discussion.**

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**I have read and understood** the patient information entitled *Consent* and the above additional information. **I agree** to the procedure or treatment.

Signed (Patient): .......................................................... Date: D.D / M.M / Y.Y.Y.Y.

Name of patient (PRINT): ...........................................................................................................

If signing for a child or young person; delete if not applicable.

**I confirm** I am a person with **parental responsibility** for the patient named on this form.

Signed: ........................................................................................ Date: D.D / M.M / Y.Y.Y.Y.

Relationship to patient: .............................................................................................................

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Signed (Witness): ................................................................. Date: D.D / M.M / Y.Y.Y.Y.

Name of witness (PRINT): ........................................................................................................

Address: ....................................................................................................................................

**D** Interpreter’s statement (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): .......................................................... Date: D.D / M.M / Y.Y.Y.Y.

Name (PRINT): .........................................................................................................................

Or, please note the language line reference ID number: ..............................................................

**E** Withdrawal of patient consent

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ............................................................. Date: D.D / M.M / Y.Y.Y.Y.

Signed (Health professional): .................................................. Date: D.D / M.M / Y.Y.Y.Y.

Name (PRINT): .........................................................................................................................

Job title: .................................................................................................................................

**F** Confirmation of patient consent

Confirmation of consent (where the treatment/procedure has been discussed in advance). On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): .................................................. Date: D.D / M.M / Y.Y.Y.Y.

Name (PRINT): .........................................................................................................................

Job title: ...................................................................................................................................