

Name of Patient: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ AM  
PM

My physician, \_\_\_\_\_, has fully discussed the nature and purpose of treatment with me. The side effects, risks, benefits and alternatives have been explained to me in as much detail as I desire. I acknowledge and understand that no guarantee or assurance has been made as to the results that may be obtained from said treatment. If any unforeseen condition arises from the treatment which requires immediate medical intervention, I further authorize the performance of such treatment.

The plan of treatment includes the following:

\_\_\_\_\_  
\_\_\_\_\_

(INFORMATION TO BE FURNISHED BY THE PHYSICIAN IN LAYMAN'S LANGUAGE)

- I understand that I may receive medications prior to my chemotherapy such as medications for nausea. I also understand that the above therapy may be adjusted as needed by my physician.
- I certify that I have read all of the above and consent to the treatment plan. I also understand that I am free to stop therapy at any time.

\_\_\_\_\_  
(Signature of Patient or Person Authorized to Consent for Patient) (Date/Time)

Relationship: \_\_\_\_\_

\_\_\_\_\_  
(Interpreter's Signature if Applicable)

Witness \_\_\_\_\_ (Date/Time)

Title \_\_\_\_\_

I have explained the risks, benefits, and alternatives of the proposed treatment to the patient and/or authorized representative. The patient and/or patient authorized representative wishes to proceed.

\_\_\_\_\_  
(Physician's Signature) (Date/Time)

I choose not to undergo the recommended treatment and assume full responsibility for the risks and consequences involved in this decision. Though I choose not to receive chemotherapy/treatment, I understand that I may still receive supportive/palliative care to alleviate symptoms that may occur in the natural course of my disease.

\_\_\_\_\_  
(Signature of Patient or Person Authorized to Consent for Patient) (Date/Time)

Relationship: \_\_\_\_\_

\_\_\_\_\_  
(Interpreter's Signature if Applicable)

Witness \_\_\_\_\_ (Date/Time)

Title \_\_\_\_\_

**AUTHORIZATION FOR CHEMOTHERAPY TREATMENT**