UNIVERSITY OF MICHIGAN HEALTH-SPARROW
MICHIGAN MEDICINE

CONSENT FOR CHEMOTHERAPY / BIOTHERAPY / IMMUNOTHERAPY

Patient Name:	
Patient DOB:	Patient MRN:

□ Herbert-Herman Cancer Center, 1140 E. Michigan Ave., Suite 200, Lansing, MI 48912
□ UM Health-Sparrow Carson, 406 E. Elm St., Carson City, MI 48811
□ UM Health-Sparrow Clinton, 805 S. Oakland St., St. Johns, MI 48879
□ UM Health-Sparrow Eaton, 321 E. Harris St., Charlotte, MI 48813
□ UM Health-Sparrow Ionia, 3565 S. State Rd., Ionia, MI 48846

I have met with my doctor regarding the recommended treatment plan for my diagnosis. I have received an explanation regarding the purpose, goal, method, dose and duration, side effects, beneficial effects, and risks related to my recommended treatment plan.

The following medications will be administered (list generic name only):

1.	4.
2.	5.
3.	6.

- I understand my treatment plan is selected based on established protocols and clinical expertise
- I understand there is no guarantee of treatment success
- I understand I can stop my treatment at any time
- I understand the contents of this consent

I have read the contents of this consent and hereby consent to pursue the treatment plan as outlined above.

PATIENT SIGNATURE:	DATE:	TIME:
SIGNATURE OF LEGAL REPRESENTATIVE (INCLUDE RELATIONSHIP):	DATE:	TIME:
WITNESS:	DATE:	TIME:

I have discussed the purpose, goal, method, dose and duration, side effects, beneficial effects, and risks related to the treatment plan outlined above. I have reviewed this consent with the patient. The patient explained what they understood from our discussion and wishes to proceed.

PROVIDER SIGNATURE:	DATE:	TIME: