Hematology Oncology
associates pc
physicians and surgeons

2828 E. BARNETT ROAD, MEDFORD, OR 97504
PHONE 541-774-5853 | **TOLL FREE** 888-774-4911 | **FAX** 541-608-6632

Med Rec #:_____
Name:_____
Birthdate: _____ Age_____
Phone (H) _____ (W) _____
PCP_____

CONSENT TO CHEMOTHERAPY

Physician: _____

Chemotherapy Procedures: _____

The chemotherapy procedures listed above have been explained to me by the doctor with their relation to the nature and purpose of the above patient's medical treatment, and I am generally aware that in such treatment medical complications can occur inherent in the nature of the treatment. I acknowledge that no guarantee or assurance has been made to me relative to the results that may be obtained.

I authorize the doctor named above and whomever he may designate to the treat the above patient with chemotherapeutic medications.

CIRCLE ONE
Permission is / is not given to obtain photographs of the patient for educational and/or diagnostic purposes.

DATE TIME PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

WITNESS RELATIONSHIP TO PATIENT

CONSENT TO CHEMOTHERAPEUTIC INTERVENTION