RADIATION ONCOLOGY DEPARTMENT

Consent for SM-153 Therapy

PATIENT NAME: ________________________________  MR#: ______________

I hereby authorize Dr. __________________________ to perform the proposed Radiation Oncology Treatment of SM-153 Therapy to my Whole Body.

I consent to have the SM-153 planning and treatments described above administered under the direction of my primary radiation oncologist, who may be assisted by other Hospital affiliated physicians, nursing, and technical staff. I understand that there may be unforeseen circumstances that are encountered while performing the above listed special procedure that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed procedure: (i) the nature and purpose of the proposed treatment; (ii) the foreseeable risks and consequences of the proposed treatment, including the risk that the proposed treatment may not achieve the desired objective; (iii), and the alternatives to the proposed treatment might include chemotherapy, surgery or no treatment and the associated risks and benefits to such alternatives.

Specifically, in obtaining my informed consent to the special procedure, I have been informed of the following reasonably foreseeable risks:

Reactions following SM-153

Common:
- Low blood counts
- Nausea/Vomiting

Uncommon: occurring in less than 10% of People treated
- Pain flare reaction
- Arrhythmias
- Diarrhea
- Abdominal pains
- Fever/chills
- Pain/swelling of injection site

Very Uncommon: less than 5%
- Dizziness
- Bleeding
- Chest pain

Long Term Reactions

Rare: occurring in less than 1 % of people treated
- Cancer caused by radiation

FOR FEMALES ONLY:

I am not pregnant now and have no reason to suspect that I am pregnant.
I understand there is a potential risk to the fetus if I become pregnant during treatment.

__________  Patient initials

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I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed treatment.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

_________________________________________ M. D. Signed: ____________________________
(Patient or legally authorized representative)
Date: ____________ Time: ____________

Interpreter responsible for explaining procedures and special treatment:

_________________________________________________ (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [ ] BECAUSE:

_________________________________________ M.D. Date: ____________ Time: ____________

_________________________________________ Witness Date: ____________ Time: ____________