



Patient Name: [REDACTED]
MRN: [REDACTED]
DOB: [REDACTED]

Avon Hospital	Fairview Hospital
Akron General	Hillcrest Hospital
Akron General Lodi Hospital	Lutheran Hospital
Cleveland Clinic	Marymount Hospital
CC Children's Hospital for Rehabilitation	Medina Hospital
CC Nevada	South Pointe Hospital
Euclid Hospital	

INFORMED CONSENT

Responsible Practitioner performing the Procedure/treatment/test: Ilia Buhtoiarov, MD
PHO team

Procedure/treatment/test: Consent for therapy with immunochemotherapy as per R-CVP protocol.

The risks, benefits, and anticipated outcomes of the procedure/treatment/test, (the "Patient's Procedure"), the alternatives to the Patient's Procedure and the risks and benefits of those alternatives, and the roles and tasks of the personnel to be involved in the Patient's Procedure were discussed with the patient or the patient's personal representative.

Interpretive Services Needed: No

<div>Signature captured with [REDACTED] 5:04 AM</div> <p>Practitioner's Signature</p>	
<p>Name of Practitioner Obtaining the Consent [REDACTED] PHO team</p>	

1. I, the patient, or my personal representative, have talked to my doctor or health care team about:

- My medical condition, what the Procedure/treatment/test is, why I am having it done, and what will happen during and after the Procedure/treatment/test.
- How it may help me (the benefits).
- How it might harm me (the most likely and serious risks, complications, and side effects).
- The equipment that will be used for the Procedure/treatment/test, to the extent that is significant to my decision making.
- My other choices for treatment and the risks and benefits of those other choices.
- What will likely happen if I say no to this Procedure/treatment/test.

2. I, the patient, or my personal representative, understand that:

- I can change my mind. If I do, I must tell my doctor or team before they start.
- If it is best for me, my doctor may change my treatment if he/she finds a serious problem or if complications arise during the Procedure/treatment/test.
- Physician trainees and assistants who are licensed by law and/or approved by Cleveland Clinic health system may observe or participate in the Procedure/treatment/test.
- The equipment used for my Procedure/treatment/test will include equipment deemed appropriate by my physician with the goal of the best possible outcome.

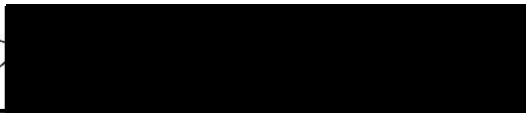


Patient Name: [REDACTED]
MRN: [REDACTED]
DOB: [REDACTED]

Avon Hospital	Fairview Hospital
Akron General	Hillcrest Hospital
Akron General Lodi Hospital	Lutheran Hospital
Cleveland Clinic	Marymount Hospital
CC Children's Hospital for Rehabilitation	Medina Hospital
CC Nevada	South Pointe Hospital
Euclid Hospital	

- e. No guarantee is made to me concerning a final result, outcome or cure.
- f. If I am a surgery patient, I am cared for by a team led by my attending surgeon. Unless otherwise specified by my surgeon, at certain non-critical portions of my surgery, my attending surgeon may leave the operating room and/or be involved in another procedure.

3. My questions have been answered to my satisfaction. I agree to the Procedure/treatment/test.

	
<i>Signature of Patient/Other Authorized Person</i>	
Individual Consenting: Patient	
Relationship to Patient (if not patient): Patient	
Witness to Telephone Consent (optional): Not Applicable	