Case I, consent for TACE.

PROCEDURES/SURGERY/SEDATION
INFORMED CONSENT PROGRESS NOTE

Requirements: This must be completed by a physician or dentist of the surgical/procedural team. It may be completed by a nurse only if he/she performs the procedure. Each section must be completed. This document must be in the patient's chart before the procedure is performed.

- Name of procedure (state right or left where applicable): Transarterial chemoembolization of multiple hepatic tumors
- Type of anesthesia or sedation: [redacted]
- The following have been discussed with the consentor in lay terms and I believe he or she understands:
  - ☑ The nature of the procedure
  - ☑ The common **risks** and **side-effects** related to the procedure and recuperation period
    Bleeding, infection, non target embolization, pain, contrast allergy, stroke, Renal failure, arterial access injury (pseudoaneurysm, dissection
  - ☑ The potential **benefits** of the procedure
  - ☑ The likelihood of achieving treatment goals
  - ☑ The reasonable **alternatives** to the procedure
  - ☑ The risks, side-effects and benefits of the alternatives and of receiving no treatment
- A blood transfusion is anticipated and a type/screen or type/cross match was done. ☐ **Yes** ☑ **No**
  If **yes**, complete the Blood Transfusion Informed Consent on the reverse side of this form.
- The patient has an advance directive or limitation of treatment order. ☐ **Yes** ☐ **No**
  If **yes**, will the provisions be suspended during the period surrounding the procedure? ☐ **Yes** ☐ **No**
- Are there language barriers or other hindrances to communication with the consentor? ☐ **Yes** ☐ **No**
  If **yes**, I have obtained the services of a qualified interpreter in obtaining informed consent.

Physician	**Patient/Legal Representative**
☑ I gave the consentor opportunity to ask questions. ☑ I have neither given nor implied any guarantees. ☑ I believe that the consentor understands, desires and accepts this procedure. ☑ I have provided a copy of this document to the consentor.	☑ The risks, side-effects, benefits and alternatives of this procedure have been explained to me and I understand them.
Signature / Pager # — Date 6/2/14 — Time 11:51am	Signature — Date 6/2/14 — Time 11:50a
Interpreter	Name of Representative — Relationship
Language of Patient	**Telephone Consent**
Name of Interpreter	Person Giving Telephone Consent — Relationship
Interpreter Signature or Telephone Interpreter ID# — Date — Time	Signature of Witness — Date — Time

BLOOD TRANSFUSION INFORMED CONSENT AND EMERGENCY CONSENT ON BACK OF THIS FORM

LOMA LINDA UNIVERSITY MEDICAL CENTER

PROCEDURES/SURGERY/SEDATION
INFORMED CONSENT PROGRESS NOTE

23-0382 (3-14)

PAT

Case II, consent for proton radiation therapy.

0713

I hereby request and authorize physicians and staff in the Department of Radiation Medicine at Loma Linda University Medical Center to administer therapy to the patient indicated below. I understand that the therapy may include one of more of the following types of treatment: x-ray, electron, proton, or radioisotope.

☐ Your procedure will require general anesthesia.

I have spoken directly with a physician of the Radiation Medicine Department who has answered to my satisfaction my questions concerning radiation therapy and alternative methods of treatment. All treatments are offered with the intention of benefiting the patient; however, benefit or cure cannot be guaranteed.

By signing this consent form, I acknowledge that I have been told of the nature of treatment and potential known reactions to such therapy. Reactions or side-effects from radiation therapy may occur during or shortly after the course of treatment ("early reactions"), or some time later ("late reactions"). Any of the side-effects or reactions may be temporary or permanent. I have been given a copy of these known reactions, which accompanies this form.

I also consent to have photographs taken for treatment purposes and for education or research purposes, or to be published in scientific journals, provided that the patient's name is not used.

ALL FEMALES: Radiation can be harmful to an unborn child.
☐ I am pregnant ☐ I could be pregnant ☐ I am not pregnant

Physician Signature

Patient Signature (or)

Witness Signature

Parent or Legal Representative

10/25/17 1430
Date & Time

Relationship to Patient

Name of Interpreter

Language of Patient/Parent/Legal Representative

Interpreter Signature or Telephone Interpreter ID#

LOMA LINDA UNIVERSITY MEDICAL CENTER
DEPARTMENT OF
RADIATION MEDICINE
RADIATION THERAPY CONSENT

PATIENT IDENTIFICATION

MRN:
DOB:

20-071.3 (04-07)

Case III, consent for TACE.

PROCEDURES/SURGERY/SEDATION
INFORMED CONSENT PROGRESS NOTE

Requirements: This must be completed by a physician or dentist of the surgical/procedural team. Each section must be completed. This document must be in the patient's chart before the procedure is performed.

- Name of procedure (state right or left where applicable): TACE (transhepatic arterial Chemoembolization)
- Type of anesthesia or sedation: moderate
- The following have been discussed with the consentor in lay terms and I believe he or she understands:
  - The nature of the procedure
  - The common **risks** and **side-effects** related to the procedure and recuperation period
    pain, nausea, bruise, damage to adjacent structures, allergic reaction, hepatic failure, technical failure, risks of chemotherapy, renal damage, post-embolization syndrome
  - The potential **benefits** of the procedure
  - The likelihood of achieving treatment goals
  - The reasonable **alternatives** to the procedure
  - The risks, side-effects and benefits of the alternatives and of receiving no treatment
- A blood transfusion is anticipated and a type/screen or type/cross match was done. ☐ **Yes** ☒ **No**
  If **yes**, complete the Blood Transfusion Informed Consent on the reverse side of this form.
- Are there language barriers or other hindrances to communication with the consentor? ☐ **Yes** ☒ **No**
  If **yes**, I have obtained the services of a qualified interpreter in obtaining informed consent.

Physician	**Patient/Legal Representative**
• I gave the consentor opportunity to ask questions. • I have neither given nor implied any guarantees. • I believe that the consentor understands, desires and accepts this procedure.	• The risks, side-effects, benefits and alternatives of this procedure have been explained to me and I understand them.
Signature / Pager # — Date: 12/20/16 — Time: 1231	Signature — Date: 12/20/16 — Time: 1234
	Name of Representative — Relationship
Interpreter	**Telephone Consent**
Language of Patient	Person Giving Telephone Consent — Relationship
Name of Interpreter	
Interpreter Signature or Telephone Interpreter ID# — Date — Time	Signature of Witness — Date — Time

BLOOD TRANSFUSION INFORMED CONSENT AND EMERGENCY CONSENT ON BACK OF THIS FORM

Case IV, consent for TACE.

PROCEDURES/SURGERY/SEDATION
INFORMED CONSENT PROGRESS NOTE

Requirements: This must be completed by a physician or dentist of the surgical/procedural team. It may be completed by a nurse only if he/she performs the procedure. Each section must be completed. This document must be in the patient's chart before the procedure is performed.

- Name of procedure (state right or left where applicable): Transarterial Chemoembolization
- Type of anesthesia or sedation: Moderate
- The following have been discussed with the consentor in lay terms and I believe he or she understands:
  - ☑ The nature of the procedure
  - ☑ The common **risks** and **side-effects** related to the procedure and recuperation period

    Bleeding, infection, regional damage, vascular damage, hepatic damage, post embolic syndrome, over sedation under
  - ☑ The potential **benefits** of the procedure
  - ☑ The likelihood of achieving treatment goals
  - ☑ The reasonable **alternatives** to the procedure
  - ☑ The risks, side-effects and benefits of the alternatives and of receiving no treatment
- A blood transfusion is anticipated and a type/screen or type/cross match was done. ☐ **Yes** ☑ **No**
  If **yes**, complete the Blood Transfusion Informed Consent on the reverse side of this form.
- The patient has an advance directive or limitation of treatment order. ☐ **Yes** ☑ **No**
  If **yes**, will the provisions be suspended during the period surrounding the procedure? ☐ **Yes** ☐ **No**
- Are there language barriers or other hindrances to communication with the consentor? ☐ **Yes** ☐ **No**
  If **yes**, I have obtained the services of a qualified interpreter in obtaining informed consent.

Physician	**Patient/Legal Representative**
☑ I gave the consentor opportunity to ask questions. ☑ I have neither given nor implied any guarantees. ☑ I believe that the consentor understands, desires and accepts this procedure. ☐ I have provided a copy of this document to the consentor.	☑ The risks, side-effects, benefits and alternatives of this procedure have been explained to me and I understand them.
Signature / Pager # — Date 6/29/15 — Time 12:36	Signature — Date 6/29/15 — Time 12:36
	Name of Representative — Relationship
Interpreter	**Telephone Consent**
Language of Patient	Person Giving Telephone Consent — Relationship
Name of Interpreter	
Interpreter Signature or Telephone Interpreter ID# — Date — Time	Signature of Witness — Date — Time

BLOOD TRANSFUSION INFORMED CONSENT AND EMERGENCY CONSENT ON BACK OF THIS FORM

PROCEDURES/SURGERY/SEDATION
INFORMED CONSENT PROGRESS NOTE

LOMA LINDA UNIVERSITY MEDICAL CENTER

SERVICES

Case IV, consent for proton therapy.

I hereby request and authorize physicians and staff in the Department of Radiation Medicine at Loma Linda University Medical Center to administer therapy to the patient indicated below. I understand that the therapy may include one of more of the following types of treatment: x-ray, electron, proton, or radioisotope.

☐ Your procedure will require general anesthesia.

I have spoken directly with a physician of the Radiation Medicine Department who has answered to my satisfaction my questions concerning radiation therapy and alternative methods of treatment. All treatments are offered with the intention of benefiting the patient; however, benefit or cure cannot be guaranteed.

By signing this consent form, I acknowledge that I have been told of the nature of treatment and potential known reactions to such therapy. Reactions or side-effects from radiation therapy may occur during or shortly after the course of treatment ("early reactions"), or some time later ("late reactions"). Any of the side-effects or reactions may be temporary or permanent. I have been given a copy of these known reactions, which accompanies this form.

I also consent to have photographs taken for treatment purposes and for education or research purposes, or to be published in scientific journals, provided that the patient's name is not used.

ALL FEMALES: Radiation can be harmful to an unborn child.
☐ I am pregnant ☐ I could be pregnant ☐ I am not pregnant

Physician Signature

Patient Signature (or)

Witness Signature

X
Parer

8/26/15 1400
Date & Time

Relationsl

Name of Interpreter

Language of Patient/Parent/Legal Representative

Interpreter Signature or Telephone Interpreter ID#

LOMA LINDA UNIVERSITY MEDICAL CENTER
DEPARTMENT OF
RADIATION MEDICINE
RADIATION THERAPY CONSENT

PAT II

CASE REPORT: The utility of PET/CT scan in detecting hepatocellular carcinoma: A Case series of PET/CT scan complementing multiphasic scans in the diagnosis and treatment response monitoring of hepatocellular carcinoma

AUTHOR/CO-AUTHOR: Michael Volk, M.D.
Jason Cheng, M.D.
Nelly Tan, M.D.

The case report form named above may be performed only by using personal information relating to your health. National data protection regulations give you the right to control the use and disclosure of your medical information. Therefore, by signing this form, you specifically authorize your medical information to be used or disclosed as described below.

Use of your personal information

The following personal information, considered "Protected Health Information" (PHI) is needed to conduct this case report and may include, but is not limited to: name, address, telephone number, date of birth, government-issued identification number, and medical and charts, including the results of all tests and procedures performed. Additionally, PHI may be shared with individuals designated to assist in conducting this case study as well as with accreditation bodies. PHI may also be reviewed to ensure that the case meets legal and institutional standards.

Disclosure of your personal information

The main reason for sharing this information is to be able to conduct a case study and present or publish the results. The results of the case study may be published in one or more publications. Although information obtained from your medical record and chart will be disclosed in the publication, we will not publish identifiers such as your name, address, telephone number or government-issued identification number. Identifiers may be used, however, for sharing information with an agency authorized to receive reports on adverse events or situations that may help prevent placing other individuals at risk.

I hereby give authorization for the use or disclosure of my personal; information for the case report based on my understanding of the following:

I understand that you may use my personal information to prepare this report. The scope of the report, however, is limited to the case description indicated above.

I understand that medical information that includes direct identifiers may be shared for the purpose of legal and institutional review as well as for the purpose of review by an accreditation body.

I understand that the authorization to use my personal information to conduct this case report will expire at the end of the study. However, I understand that following publication, full articles or abstracts of or from the initial report may be published and continue to be published for an indefinite period of time.

I understand that this authorization does not authorize the use or disclosure of personal information created or obtained after initial publication.

I understand that I do not need to sign this authorization in order to receive health care.

I understand that I may revoke this authorization at any time. However, the revocation will not apply to information that has already been released in response to this authorization.

I agree that my personal health information may be used for the purpose described in this form.

Name of Patient: [redacted]
(Please print full name)

Signature of Patient: [redacted]

Date: 1-6-20 Time: 11:40