

THALIDOMIDE; *Checklist for Prescribers*

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|--|------------------|
| 1 Has the patient signed a consent form? | Yes/No |
| 2 Has the patient received an information leaflet? | Yes/No |
| 3 Is the patient a woman of potentially child-bearing age?
If 'yes', has pregnancy been excluded? | Yes/No
Yes/No |
| Has appropriate contraceptive advice been provided? | Yes/No |
| 4 Have baseline nerve conduction studies been done? | Yes/No |
| 5 Date for follow-up nerve conduction studies | |

Modified from British Journal of Dermatology, 2002; 144. 310- 3 15

A patient has the right under common law to give or withhold consent to medical examination of treatment. This is one of the basic principles of health care. Patients are entitled to receive sufficient information in a way they can understand about the proposed treatments, the possible alternatives and any substantial risk or risks which may be special in kind or magnitude or special to the patient, so that they can make a balanced judgement. (UK Health Dept.19.2.99. HSC 1999/031)

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THALIDOMIDE; *Consent form for treatment*

Dr has recommended using thalidomide to treat your oral condition. Please read the following statements and sign below if you wish and agree to proceed with this treatment.

- I have been informed about the use of thalidomide and its possible side-effects.
- I have been informed of its potential to cause severe damage to unborn babies, and to cause nerve damage and drowsiness.
- I have been provided with an information leaflet explaining these possible problems.
- I understand these, and agree to the following:

Female patients only:

1. If I could be pregnant, I agree to have a pregnancy test before starting treatment with thalidomide. I understand that this pregnancy test must be negative,
2. I agree to take effective contraceptive measures while taking thalidomide, and for 3 months after stopping the tablets.
3. If I miss a menstrual period while taking thalidomide, I will stop taking the drug immediately and inform my doctor.

All patients:

1. If I develop any pins and needles, tingling or numbness during treatment with thalidomide I will stop taking thalidomide and inform my doctor.
2. I agree never to give thalidomide tablets to any other person than the doctor or pharmacist.
2. I agree to return any unused supplies of thalidomide on stopping treatment.

Patient Surname.....First name.....
Number.....
Birth date.....
Address.....
.....
SignatureDate

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