

CONSENT TO TREATMENT OF INTERFERON / RIBAVIRIN

The physician should initial numbers 1 through 11 after discussing each with the inmate.

I, _____, Reg. No. _____, hereby authorize Dr. _____

or his/her relief (designee), to prescribe interferon (Intron A®, PEG-Intron®, Pegasys®) and ribavirin (Rebetol®, Copegus®) to me and to continue said medication as is recommended by BOP Clinical Practice Guidelines. I understand my medical condition and why this combination of medications is being recommended to treat my disease.

1. _____ The combination of ribavirin capsules and interferon injections is indicated for the treatment of hepatitis C in certain patients. This treatment is associated with numerous adverse and potentially serious side effects*. Your doctor, along with pharmacy and laboratory, will carefully monitor you for side effects and your response to this therapy.
2. _____ The most common side effects of this treatment are "flu-like" symptoms, such as headache, fatigue, muscle aches, and fever. These symptoms may decrease in severity as treatment continues. Taking acetaminophen (Tylenol®) prior to interferon administration may help alleviate some of these adverse effects.
3. _____ Psychiatric problems, such as insomnia and depression, are also frequently associated with this therapy. If you feel you are getting irritable or easily upset, feel hopeless or bad about yourself, or experience any other uncommon psychological problems, you should immediately contact your physician.
4. _____ Some patients will develop blood problems such as reduced red blood cells (anemia), or reduced white blood cells and platelets. Between 5%-10% of the patients taking ribavirin therapy develop anemia within 1 to 4 weeks of beginning treatment. You will receive a Complete Blood Count on a regular basis to determine if you are developing anemia. Your white blood cells and platelets will also be closely monitored. If these levels drop below acceptable levels you may need to discontinue the medication.
5. _____ Your thyroid function will be closely monitored because a small percentage of patients (approximately 4%) will develop thyroid dysfunction that may be irreversible, even if treatment is discontinued.
6. _____ Other common side effects include bruising, irritation, or itchiness at the injection site, nasal stuffiness, and reversible thinning of the hair.
7. _____ **Ribavirin can cause birth defects. Both women and men, particularly those awaiting release, must be counseled to use adequate birth control (2 forms of birth control) during treatment and 6 months after treatment is completed.**
8. _____ **Abstain from illicit drug or alcohol use.**
9. _____ **Ribavirin should not be taken if you have severe kidney dysfunction.**
10. _____ You should immediately speak to your doctor if you experience any side effects described above, or you experience trouble breathing, chest pain, severe stomach or lower back pain, bloody diarrhea or bloody bowel movements, high fever, bruising, bleeding, decreased vision, weight loss, rashes, or other symptoms that concern you.
11. _____ To improve your comfort and the chances of successfully completing this course of treatment you should, get plenty of rest, exercise lightly but regularly, drink plenty of water or clear fluids every day, eat regularly, and take acetaminophen for fevers and "flu-like" symptoms.

Based upon interview, assessment, and medical record review, it is my opinion that this patient understands the proposed treatment, the risks and benefits of the treatment, and **is competent** to give consent.

Physician Signature _____

Based upon interview, assessment, and medical record review, it is my opinion that this patient understands the proposed treatment, and **is not competent** to give consent.

Physician Signature _____

Other issues discussed:		
I certify that I have read the foregoing, or have had it explained to me in a language that I understand, and hereby consent to treatment and have no additional questions. I understand that I may stop taking this medication by contacting the physician. However, I understand that discontinuing the medication may result in failure to control progression of liver disease.		
Inmate Signature:	Reg. No.:	Date:
Witness Signature:		Date:
Attending Physician:		

* Your doctor will review the risks and benefits of treatment for you.