

## PATIENT CONSENT FORM

### USE OF TOCILIZUMAB IN HOSPITALISED ADULTS WITH COVID-19

Tocilizumab (Actemra®) is registered for use in Australia for the treatment of arthritis, giant cell arteritis and cytokine release syndrome, but not for the treatment of COVID-19. Australia's [National COVID-19 Clinical Evidence Taskforce](#) has made recommendations about when tocilizumab is most likely to be effective in the treatment of COVID-19.

#### PATIENT CONSENT

By signing this form, I \_\_\_\_\_ understand that:

*(write name of patient / person responsible)*

- tocilizumab (Actemra®) is not registered for use in Australia for the treatment of COVID-19;
- there are no guarantees of the effectiveness of tocilizumab when it is used to treat COVID-19 and I/the person I am responsible for may not experience any benefit;
- there are no guarantees of the safety of tocilizumab when it is used to treat COVID-19 and even with careful precautions in place, unforeseen complications may occur;
- there is potential for drug interactions (known and unknown) with the use of tocilizumab; and,
- there is a possibility of experiencing side effects with the use of tocilizumab (known and unknown).

I confirm that I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I can change my mind and withdraw my consent to being treated with tocilizumab at any time.

With this knowledge, I **consent** to the use of tocilizumab in the treatment of me/the person I am responsible for.

Patient's name: \_\_\_\_\_ MRN: \_\_\_\_\_ Age: \_\_\_\_\_

Signature of patient (or person responsible\*): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If applicable, name & signature of witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness is not to be a member of the treating team. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

\*If the person responsible has signed, please provide details below:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Reason for representation: \_\_\_\_\_

#### DOCTOR'S DECLARATION

I have provided to the patient/their person responsible an explanation of the use of tocilizumab, its potential benefits and harms and the relevant [Patient Information Leaflet](#). I believe the information has been understood.

Please print & sign this form and file with the patients' Health Record. Further consenting information can be found [here](#).

Doctors name & designation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If the patient cannot converse adequately in English, please use an accredited Health Care interpreter. Do not rely on relatives or other parties for interpreting.

Language: \_\_\_\_\_ Name of interpreter & ID #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Completed signed form should be kept in the patient's Health Record.*