

CONSENT FOR SPECIAL STUDY AND TREATMENT

I, \_\_\_\_\_, do hereby give my consent to the members of the professional staff of the Cincinnati General Hospital, University of Cincinnati College of Medicine, to perform a bone marrow aspiration and to store my bone marrow on or about \_\_\_\_\_, 196\_\_.

The nature and purpose of this therapy, the risks involved, the possibility of complications, and prognosis have been fully explained to me. The special study and research nature of this treatment has been discussed with me and is understood by me.

Consent is also given for reinfusion (giving the marrow back to me) when the members of the professional staff recommend it.

Consent is given for photographs and publication for the advancement of medical education.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship  
(patient or guardian)

\_\_\_\_\_  
Date  
AM  
PM  
(Mo. Day Yr.)

\_\_\_\_\_  
Place  
(Ward - Clinic - Unit)

\_\_\_\_\_  
Chart No.

Witnesses to signature:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Original: to patient's chart  
Copies: to Co-60 file  
to TBR file

5/1/65

CONSENT FOR SPECIAL STUDY AND TREATMENT

I, \_\_\_\_\_, do hereby give my consent to the members of the professional staff of the Cincinnati General Hospital, University of Cincinnati College of Medicine, to administer to me whole or partial body irradiation on or about \_\_\_\_\_, 196\_\_.

The nature and purpose of this therapy, possible alternative methods of treatment, the risks involved, the possibility of complications, and prognosis have been fully explained to me. The special study and research nature of this treatment has been discussed with me and is understood by me.

Consent is given for photographs and publication for the advancement of medical education.

Witnesses to signature:

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_

Relationship \_\_\_\_\_  
(patient or guardian)

Date \_\_\_\_\_  
AM  
PM  
(Mo. Day Yr.)

Place \_\_\_\_\_  
(Ward - Clinic - Unit)

Original: to patient's chart  
Copies: to Co-60 file  
to TBR file

Chart No. \_\_\_\_\_

5/1/65

UNIVERSITY OF CINCINNATI MEDICAL CENTER  
FACULTY COMMITTEE ON RESEARCH  
VOLUNTARY CONSENT STATEMENT

\*I \_\_\_\_\_ of \_\_\_\_\_  
(Patient) (normal subject) (place - city)

being of the age of majority and of sound mind and body, voluntarily and without force or duress, consent to participate in a scientific investigation which is not directed specifically to my own benefit, but in consideration for the expected advancement of medical knowledge, which may result for the benefit of mankind.

I have been informed of and understand the nature, duration, and purpose of the study, the method and means by which it is to be conducted, the inconvenience and hazards to be expected, and the effects upon my health and person which may possibly come from participation in the experiment, as follows:

**Purpose:** To kill tumor cells and at the same time study the effects of radiation on blood and urine:

**Procedure:** Radiation of the whole body.

**Risks:** The chance of infection or mild bleeding to be treated with marrow transplant, drugs, or transfusion as needed.

I understand that I may, at any time during the course of the experiment, revoke my consent, in writing, and withdraw from the experiment.

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained, and I hereby waive any and all claims for liability, except for negligence, on the part of the medical personnel involved, the University of Cincinnati, its Hospital and its Medical School, which otherwise might have inured to me or my heirs, as a result of this medical procedure.

I certify that I have read and am competent to fully understand this consent and that the explanations listed above were, in fact, made.

Volunteer \_\_\_\_\_ Date \_\_\_\_\_

Investigator \_\_\_\_\_ Date \_\_\_\_\_

Witness (1) \_\_\_\_\_ Date \_\_\_\_\_

\*In case of subject under age, the parent or guardian should be the responsible party and should sign on his behalf.

NOTE: Copy to Patient/normal subject, Research File and Patient's Chart.

CONSENT FOR SPECIAL STUDY AND TREATMENT

I, \_\_\_\_\_, do hereby give my consent to the members of the professional staff of the Cincinnati General Hospital, University of Cincinnati College of Medicine, to administer to me whole or partial body irradiation and marrow autotransplant on or about \_\_\_\_\_, 196\_\_.

The nature and purpose of this therapy, possible alternative methods of treatment, the risks involved, the possibility of complications, and prognosis have been fully explained to me. The special study and research nature of this treatment has been discussed with me and is understood by me.

Consent is given for photographs and publication for the advancement of medical education.

Witnesses to signature:

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_

Relationship \_\_\_\_\_  
(patient or guardian)

Date \_\_\_\_\_  
AM  
PM  
(Mo. Day Yr.)

Place \_\_\_\_\_  
(Ward - Clinic - Unit)

Chart No. \_\_\_\_\_

Original: to patient's chart  
Copies: to Co-60 file  
to TBR file

5/1/65

UNIVERSITY OF CINCINNATI MEDICAL CENTER  
FACULTY COMMITTEE ON RESEARCH  
VOLUNTARY CONSENT STATEMENT

\*I \_\_\_\_\_ of \_\_\_\_\_  
(Patient) (Normal subject)

being of the age of majority and of sound mind and body, voluntarily and without force or duress; consent to participate in a scientific investigation which is not only directed specifically to my own benefit, but also in consideration for the expected advancement of medical knowledge, which may result for the benefit of mankind.

I have been informed of and understand the nature, duration, and purpose of the study, the method and means by which it is to be conducted, the inconvenience and hazards to be expected, and the effects upon my health and person which may possibly come from participation in the experiment, as follows:

Purpose: To kill tumor cells and at the same time study the effects of radiation on blood and urine.

Procedure: Radiation of the whole body.

Risks: Radiation treatment employed is used to kill tumor cells but at the same time other, normal, cells of your body will be affected. The only cells affected which would cause any risk to you are those cells in your bone marrow. The bone marrow is a "blood factory" where white cells that fight infection, the platelets which help blood clot, and the red cells which carry oxygen to your tissues are made. The bone marrow's ability to make these cells will be decreased for four or five weeks after you receive your radiation. If you receive a dose of radiation of 200 rads or more, which your doctor will tell you, your blood counts will fall to levels where infection or bleeding could be a problem. The bleeding can be treated by transfusion of red cells and platelets and the infection by antibiotics. In addition, we prevent such low blood counts with the use of a bone marrow transplant which will be discussed with you in a separate voluntary consent statement. If your radiation dose is only given to part of the body there is no risk of danger or unusually low blood counts.

I understand that I may, at any time during the course of the experiment, revoke my consent, in writing, and withdraw from the experiment.

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained, and I hereby waive any and all claims for liability, except for negligence, on the part of the medical personnel involved, the University of Cincinnati its Hospital and its Medical School, which otherwise might have inured to me or my heirs, as a result of this medical procedure.

I certify that I have read and am competent to understand this consent and that the explanation listed above was, in fact, made.

Volunteer \_\_\_\_\_ Date \_\_\_\_\_

Investigator \_\_\_\_\_ Date \_\_\_\_\_

Witness (1) \_\_\_\_\_ Date \_\_\_\_\_

\* In case of subject under age, the parent or guardian should be the responsible party and should sign on his behalf.

NOTE: Copy to Patient/Normal subject, Research File and Patient's Chart.

UNIVERSITY OF CINCINNATI MEDICAL CENTER  
FACULTY COMMITTEE ON RESEARCH  
VOLUNTARY CONSENT STATEMENT

\*I \_\_\_\_\_ of \_\_\_\_\_  
(Patient) (Normal subject)

being of the age of majority and of sound mind and body, voluntarily and without force or duress, consent to participate in a scientific investigation which is not only directed specifically to my own benefit, but also in consideration for the expected advancement of medical knowledge, which may result for the benefit of mankind.

I have been informed of and understand the nature, duration, and purpose of the study, the method and means by which it is to be conducted, the inconveniences and hazards to be expected, and the effects upon my health as follows:

Purpose: To prevent low blood counts following radiation of your body.

Procedure: Bone marrow transplantation.

Risks: You will be put to sleep in the operating room while approximately one pint of bone marrow is removed by needles from your pelvic bones and breast bone. No operation is performed - there is no cutting. The procedure would be painful if you were not put to sleep at this time. There is almost no risk in general anesthesia. After you awaken, your lower back and chest may be somewhat sore and will be treated with pain killers if you so desire. You will then receive your radiation treatment while lying on a stretcher and be taken back to your room. At this time, your bone marrow will be given back to you through a vein just as any blood transfusion would. The risk of receiving your own blood is zero. In the bone marrow there are many globules of fat and tiny pieces of bone all of which are filtered out of the bone marrow material which you will receive before it enters your body.

I understand that I may, at any time during the course of the experiment, revoke my consent, in writing, and withdraw from the experiment.

I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained, and I hereby waive any and all claims for liability, except for negligence, on the part of the medical personnel involved, the University of Cincinnati, its Hospital and its Medical School, which otherwise might have inured to me or my heirs, as a result of the medical procedure.

I certify that I have read and am competent to understand this consent and that the explanation listed above was, in fact, made.

Volunteer \_\_\_\_\_ Date \_\_\_\_\_

Investigator \_\_\_\_\_ Date \_\_\_\_\_

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