OAK RIDGE ASSOCIATED UNIVERSITIES
Oak Ridge, Tennessee

ACH2.950206.017

Consent to Experimental Treatment

I authorize the performance upon _____ (myself or name of patient)
of the following treatment: _____

_____

_____

(State nature of treatment)

The nature and purpose of the treatment, possible alternative methods of treatment, the risks involved, and the possibilities of complications have been explained to me. I understand that this treatment is not the usual treatment for my disorder and is therefore experimental and remains unproven by medical experience so that the consequences may be unpredictable.

DATE: 70 _____
(Patient or person authorized to consent for patient)

WITNESS: _____

_____

I have talked with _____ about
Name
the proposed course of treatment to be given _____
Name
including the following:* _____

_____

_____ 7
Physician Date

*Physician should indicate experimental drugs, radioisotopes, radiation therapy, and/or possible placebo or sham therapy.