Stanford HEALTH CARE

CONSENT FOR METHOTREXATE ADMINISTRATION

I authorize Dr. _____ and such Physicians, Associates, or Nurses to perform the following (in medical terms known as):

Administration of Methotrexate, a cytotoxic substance, intramuscular injection for persistent trophoblastic tissue within the body (in common terms known as):

Giving a shot of the drug; methotrexate, into the muscle in the hip to cause the termination of an ectopic pregnancy to prevent the rupture of a tube or further complications.

Methotrexate (MTX) is a chemotherapeutic medication used to treat some ectopic pregnancies or early miscarriages. It has FDA approval for use in treating tumors, psoriasis and arthritis. It works by preventing the cells or an early pregnancy to multiply, causing these cells to die. Though it is widely used in the treatment of ectopic pregnancies, it does not yet have FDA approval for this indication. Successful treatment with Methotrexate can reduce the need for surgery due to an abnormal pregnancy. More than 95% of patients treated with Methotrexate are able to avoid surgery.

GENERAL RISKS AND POTENTIAL COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment with methotrexate as described to me by the physician and staff. These risks include nausea, vomiting, sore mouth, stomach upset, dizziness, increased abdominal pain, vaginal bleeding, infection, and death.

AVOID:

- Alcohol
- Intercourse (until Physician advises)
- Any vitamins containing folic acid
- Sun exposure and tanning booths
- Aspirin or medications with aspirin in them (ibuprofen, Aleve, Advil, Motrin, etc.).

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this treatment including (physician to describe specific risks where applicable):

- Mouth Ulcers
- Reduction in red and white blood cell count, blood loss
- Reduction in the platelet count
- Rupture of an ectopic pregnancy
- Temporary dysfunction of the liver
- Increased lower abdominal pain within 1-5 days of the injection.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of the alternative procedures or treatments and their possible benefits and risks including (physician to describe specific alternative procedures and complications where applicable):

- Observation
- Dilation and curettage (surgical removal of the uterine lining)
- Laparoscopy (looking surgically inside the abdomen with a specialized scope).

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment or procedure.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT: I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from or in addition to the methotrexate injection.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed, and I further authorize the disposal of any tissue in accordance with customary facility biohazard policy.

NO GUARANTEES: I understand there are risks involved in any procedure or treatment and it is not possible to guarantee or give assurance of a successful result.

OTHER QUESTIONS: I am satisfied with my understanding of the nature of this treatment and have had all my questions answered to my complete understanding and satisfaction. I have no further questions.

I have read and understand the information provided to me about the methotrexate injection. I give my permission to have this medication administered. I have been given written instructions and information on adverse reactions. If I have any questions or problems, I will contact the office immediately.

_____ _____
Patient Signature Date

_____ _____
Physician Date

_____ _____
Witness Date