CONSENT FORM FOR METHOTREXATE TREATMENT

OF ECTOPIC PREGNANCY

 At the recommendation of my physician, Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, I am requesting to be treated with methotrexate as a medical alternative to either surgery or continued observation for my un-ruptured ectopic pregnancy.

 I understand that this treatment consists of an injection of methotrexate, a drug used to destroy pregnancy tissue. Before treatment begins, several blood tests will be done. Blood work will consist of a blood count (CBC with differential and platelets), a test of liver function (SGOT), blood type and Rh and the pregnancy hormone (HCG.) HCG levels will be checked on days 4 and 7 after methotrexate is given. If on day 7 the HCG level is not falling appropriately, a second dose of methotrexate will be given and the pregnancy hormone levels followed again on day 11 and 14. Once the HCG level is falling, it will be checked weekly until negative.

 I have been given a patient instruction sheet and I will comply with these recommendations.

 Although no serious side effects have been seen with the single-dose protocol, some of the risks that may occur include stomatitis (inflammation and irritation inside the mouth), increase in liver function tests, decrease in blood counts and platelets, bloating and gas pains. Approximately 4 – 5% of patients do not respond to methotrexate and require surgery.

 I understand that I will probably have abdominal pain for several days as the pregnancy “dissolves”. If during the treatment I should have abdominal pain that cannot be controlled with pain medication, being or feeling weak or faint, have increased vaginal bleeding, or have any problems that I feel are related to the treatment, I should contact Dr.Farringer, Dr. Najima or the on call physician immediately at (775) 323-1300.

 I have read and understand this consent form. I understand that Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

is the responsible physician and any questions that I may have had have been answered to my satisfaction. I also understand I may withdraw my consent at any time and choose an alternative approach to my problem.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_