

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
DISCLOSURE AND CONSENT DRUG THERAPY FOR TREATMENT OF HANSEN'S
DISEASE**

The information in this consent form is given so you can know more about your treatment. After you are sure that you understand this information, sign this form to show that you do understand and agree to the treatment.

I have been told that I need drug therapy because of Hansen's Disease.

The following medications have been prescribed: **CIRCLE ALL THAT APPLY**

- | | |
|-----------------------|----------------|
| 1. Dapsone (DDS) | 4. Thalidomide |
| 2. Rifampin | 5. Other _____ |
| 3. Clofazimine (B663) | |

These drugs may carry certain risks as shown below:

DRUG	SIDE EFFECTS
Dapsone	Nausea, vomiting, loss of appetite, headaches, nervousness, inability to sleep, blurred vision, changes in mental state, neuritis, swelling of hands and feet
Rifampin	Orange tears and urine, flu-like symptoms, nausea, vomiting, loss of appetite, yellow skin, rash, itching, headaches, drowsiness. May reduce the effectiveness of birth control pills. If contraception is desired, an alternative method of birth control should be used
Clofazimine	Darkens skin from pink to brownish-black, skin dryness, itching, rash, pain in abdomen, diarrhea, nausea and vomiting, dryness, burning and itching of eyes, red coloration of sweat, tears, urine and feces
Thalidomide	Drowsiness, serious birth defects to infants born to mothers who take it during pregnancy, swelling of hands and feet

Allergic reactions including rashes may be caused by any of the drugs.

The risks are small and the health problems that may arise usually clear up completely. Sometimes the side effects may be bad, and very rarely may cause lasting damage or death. The Texas Department of State Health Services will check me regularly for side effects. I will be responsible for following treatment recommendations and instructions.

The Texas Department of State Health Services believes that the benefits of drug treatment for Hansen's Disease are much greater than the risks involved.

I have answered all of the questions about my medical history and my present health condition fully and truthfully. I have told the doctor or other clinic staff about my conditions that might show I should not take the medication(s).

I have had the chance to ask questions about this health condition. The benefits and risks of specific Hansen's Disease drugs have been explained to me. How long these side effects may last and how bad the side effects may be as well as the risks of not taking treatment have also been explained. I understand that no promises can be made about cure or side effects.

Instructions for the use of the drug(s) have been given to me as follows:

Orally

Written

(Check One) I have read the form or I have had the form read to me and it has been fully explained to me. All blank lines have been filled in.

Based on the above, I give this informed consent for the treatment as recommended.

SIGNATURES

Section I:

Patient's Name: _____

Patient's Signature: _____

Person Authorized to Consent
(if not patient): _____

Relationship: _____

Signature: _____ Date: _____

Section II:

I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Patient's Name: _____

Name of Person giving consent: _____

Signature: _____

Relationship to patient: _____ Date: _____

Address: _____ Phone Number: _____

Section III:

Name of Counselor: _____

Counselor Signature: _____ Date: _____