Brigham and Women's Hospital
Founding Member, Mass General Brigham

Patient identification area

Alzheimer Therapeutics Program (ATP)
PATIENT CONSENT TO TREATMENT WITH A MONOCLONAL ANTIBODY FOR ALZHEIMER DISEASE

I allow [Provider Name] _____and my care team in the ATP to treat

me with [drug name]_____.

I have been told the risks and benefits of this treatment. I also know that there are other choices to treat my condition. I understand the risks and benefits of these other choices.

I understand that all medical care involves some uncertainty. I understand there is no guarantee that I will get the benefits of this medication.

My care team explained the risks below:

- Reactions to the medication going in the vein, including fever, chills, body aches, blood pressure changes, and rash.
- Areas of swelling and associated bleeding in the brain. In rare cases, these may be severe and irreversible, require hospitalization, or even cause death.
- The risk of swelling and bleeding are increased if I have a certain gene. My team has tested me for this gene and explained if my risks are higher.

I have been told how often I will be receiving treatments, the ways in which I will be carefully monitored, and the kinds of symptoms that would require me to seek urgent medical attention.

I understand that my care team may stop treatments if I experience serious side effects or if I decline to the point in which I would be considered to have moderately severe, rather than mild disease.

I have received teaching materials that help me understand the information explained to me. The materials discuss side effects of the treatment in more detail. I understand that the treatment may have unexpected side effects that are not explained above.

I understand that other people may be in the room during my treatments. This includes observers, nurses, or other members of the ATP care team.

I had a chance to ask questions about the risks, benefits, and side effects of the medication treatment. I was also able to ask questions about the chances of achieving the goals of the treatment and other options. All my questions were answered. I agree to the treatment.

				AM
Patient/Legal Surrogate Decision Maker Signature	Printed Name	Date	Time	PM

I, the medical provider in the ATP, attest that I have discussed all the relevant aspects of this treatment, including the indications, risks, and benefits, as compared with alternative approaches, with the patient and answered their questions.

				AM
Attending/Practitioner Signature	Printed Name	Date	Time	PM

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