



**DIGESTIVE HEALTH CONSULTANTS**  
Of Northern California

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## Consent for Hepatitis C Treatment

Patient  
Initials

- \_\_\_\_\_ I have attended the hepatitis C instruction class.
- \_\_\_\_\_ I understand the side effects that may occur with pegylated interferon and ribavirin, some of which may be irreversible.
- \_\_\_\_\_ I will enroll in the Hepatitis C Support Program and I know that I can call this program anytime if I have questions about my treatment or side effects.
- \_\_\_\_\_ I am aware of the side effects that may be serious and need to be reported immediately.
- \_\_\_\_\_ I know that if I have severe side effects in the evenings or on weekends I can call the office at (707) 544-5093 and ask to speak with the Gastroenterology physician on call, or go the emergency room.
- \_\_\_\_\_ I understand that I must not get pregnant or father a child while taking my treatment and for six months afterward. I will not start this medication if my spouse is currently pregnant.
- \_\_\_\_\_ If I am sexually active I will use two forms of birth control while on treatment and for six months afterward.
- \_\_\_\_\_ I am responsible for making sure I do not run out of medication.
- \_\_\_\_\_ I will take my medication exactly as directed. I will read the complete package insert provided by the pharmaceutical company.
- \_\_\_\_\_ I will notify my treating provider if I miss or stop doses of medication.
- \_\_\_\_\_ I have had or will have a complete fundus eye exam prior to treatment.
- \_\_\_\_\_ I am responsible for going to the laboratory a few days prior to my appointments.
- \_\_\_\_\_ I am responsible for coming to all my appointments or notifying the staff at Digestive Health Consultants if I need to reschedule an appointment and/or miss an appointment.

**Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_