Appendix 1

Directorate of Infection

Consent form for IV amikacin treatment at home

Clinically stable patients who require intravenous antibiotics often have them administered in a home setting within this Trust. Amikacin IV therapy combined with other antibiotics is considered a life saving essential component of mycobacterial infections treatment. For it to be effective long courses are required. When used long term your hearing and kidneys can be affected. The likelihood of this occurring can be reduced if any of the side-effects below are reported to your doctor or nurse promptly;

- Hearing loss, dizziness, roaring in the ears, vertigo, loss of balance or tinnitus (ringing in the ears)
- Numbness, skin tingling, or muscle twitching
- Rash (moderate to severe) or vomiting

To further help reduce the risk of you experiencing these side-effects it is important that we take blood samples to monitor amikacin levels and also assess your kidney function on a weekly basis.

In order to have amikacin at home you need to

- Be aware of the possible long term side-effects of treatment.
- Report any side effects promptly
- Attend outpatient appointment as required to allow treatment to be monitored.
- Undertake weekly blood tests.
- Allow visits from the Home IV team and TB nurse if relevant
- Inform the hospital doctors of any new medicines prescribed by the GP. Those that may dehydrate you or affect your kidneys can alter the amount of amikacin in your blood.

Carrying out intravenous antibiotics at home may appear to be the best option to allow you to continue as near normal a lifestyle as possible. There are certain factors that will need to be considered for this to continue;

- Your present medical condition
- Venous access

Please note; there may be times when it will be decided that it is inappropriate for you to have your treatment at home.

Signing this form indicates you agree with the statements below; (tick boxes)

1. I have understood the information that has been given to me ☐
2. I understand I may get side effects and I must report these ☐
3. I understand I need to attend for drug level monitoring and doctor appointments ☐
4. I understand that I may suffer adverse effects such as hearing impairment that may be permanent ☐

(Original form to be filed in notes and photocopy given to patient)

Patients name: Patients signature:

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NHS number..... ..... PID number..... Ward..... Site:..... Date:.....

Doctors Name Doctors Signature:

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