

Radiotherapy consent form for benign skin and soft tissue conditions

This form should only be used if the patient is over 16 years old and has capacity to give consent. If the patient does not legally have capacity please use an appropriate alternative consent form from your hospital.

Patient details

Patient name:

Date of birth:

Patient unique identifier:

Name of hospital:

Responsible consultant oncologist or consultant therapeutic radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy

Radiotherapy type:

- External beam radiotherapy
- Brachytherapy to the skin

Site and side:
(Tick as appropriate)

- Site
- Left
 - Right
 - Central

Aim of treatment:
(Tick as appropriate)

You may have questions before starting, during or after your radiotherapy.

Contact details are provided here for any further queries, concerns or if you would like to discuss your treatment further.

Patient name:

Patient unique identifier:

Possible early or short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected 50%–100% 	<input type="checkbox"/> Tiredness <input type="checkbox"/> Skin irritation, itching, flaking, peeling, scaling, dryness, colour changes in the treatment area – redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones <input type="checkbox"/> The skin may scab over several times <input type="checkbox"/> Skin breakdown in the treatment area – for example oozing, weeping, scabbing and/or bleeding <input type="checkbox"/> Hair thinning or loss in radiotherapy area
Common 10%–50% 	<input type="checkbox"/> Soreness that may require non-prescription painkillers available from a pharmacy <input type="checkbox"/> Delay in wound healing
Less common Less than 10% 	<input type="checkbox"/> Infection in the treated area needing antibiotics
Rare Less than 1% 	
Specific risks to you from your treatment	Nose <input type="checkbox"/> Soreness, dryness, crusting or bleeding Lip and cheek <input type="checkbox"/> Swelling or pain Eyelids <input type="checkbox"/> Soreness <input type="checkbox"/> Impact on mobility and function Other
	I confirm that I have had the above side-effects explained.
	Patient initials <input type="text"/>

Patient name:

Patient unique identifier:

Possible late or long-term side-effects

May happen many months or years after radiotherapy and may be permanent.
Frequencies are approximate.

Expected 50%–100% 	<input type="checkbox"/> Permanent skin texture changes in treatment area – including thicker or thinner skin <input type="checkbox"/> Skin colour change in the treatment area – usually lighter or darker for any skin tone <input type="checkbox"/> Permanent hair loss in and around treatment area – if hair starts to regrow, it may be patchy or a change in texture
Common 10%–50% 	<input type="checkbox"/> Telangiectasia in the treatment area – small visible blood vessels which look like spidery marks <input type="checkbox"/> Altered sensitivity of the treated skin to the sun and changes in temperature <input type="checkbox"/> Anhidrosis in the treatment area – loss of function of sweat glands causing them to reduce or stop sweat production
Less common Less than 10% 	<input type="checkbox"/> Chronic non-healing ulcer – this may require further treatment such as dressings or surgery
Rare Less than 1% 	<input type="checkbox"/> Permanent damage to cartilage or bone in the treated area <input type="checkbox"/> A cancer in the treatment area – which may occur many years after treatment
Specific risks to you from your treatment	Nose <input type="checkbox"/> Runny nose or nose dryness Eyes <input type="checkbox"/> Dry eye or watery eye which may require further treatment <input type="checkbox"/> Ectropion – eyelid turns outwards/droops <input type="checkbox"/> Cataracts – clouding in the lens of the eye, which may require surgery to correct Mouth <input type="checkbox"/> Xerostomia – a dry mouth caused by a reduction in the production of saliva by the salivary glands Other
	I confirm that I have had the above side-effects explained.
	Patient initials

Patient name:

Patient unique identifier:

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure)

- I have discussed what the treatment is likely to involve, the intended aims and side-effects of this treatment.
- I have also discussed the benefits and risks of any available alternative treatments including no treatment.
- I have discussed any particular concerns of this patient.

Patient information leaflet provided: Yes / No – Details: _____

Copy of consent form accepted by patient: Yes / No

Signature:

Date:

Name:

Job title:

Statement of patient

- I have had the aims and possible side effects of treatment explained to me and the opportunity to discuss alternative treatment and I agree to the course of treatment described on this form.
- I understand that a guarantee cannot be given that a particular person will perform the radiotherapy. The person will, however, have appropriate expertise.
- I have been told about additional procedures which are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks and photographs to help with treatment planning and identification.
- I agree that information collected during my treatment, including images and my health records may be used for education, audit and research. All information will be anonymised. I am aware I can withdraw consent at anytime.

Tick if relevant

- I confirm that there is no risk that I could be pregnant.
- I understand that I should not become pregnant during treatment.

Note: if there is any possibility of you being pregnant you must tell your hospital doctor/health professional before your treatment as this can cause significant harm to an unborn fetus. Testosterone and other hormone treatments are not contraception.

- I understand that I should not conceive a child or donate sperm or eggs during the course of my treatment and I will discuss with my oncologist when it will be safe for me to conceive a child after radiotherapy.

- I understand that if I were to continue to smoke it could have a significant impact on the side-effects I experience and the efficacy of my treatment.

- I do not have a pacemaker and/or implantable cardioverter defibrillator (ICD).

or

- I have a pacemaker and/or implantable cardioverter defibrillator (ICD) and I have had the risks associated with this explained to me.

Signature:

Patient name:

Date:

Statement of:

- interpreter
- witness (where appropriate)

- I have interpreted the information contained in this form to the patient to the best of my ability and in a way in which I believe they can understand.

or

- I confirm that the patient is unable to sign but has indicated their consent.

Signature:

Name:

Date:

Patient confirmation of consent

(To be signed prior to the start of radiotherapy)

I confirm that I have no further questions and wish to go ahead with treatment.

Patient initials

Date: