The Royal College of Radiologists

Radiotherapy consent form for lymphoma

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**
Site:	
Aim of treatment: (Tick as appropriate)	☐ **Curative** – treatment given with the intent of curing your cancer ☐ **Palliative** – to prevent, reduce or delay the symptoms but not to cure your cancer

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/short-term side-effects

These depend on which area of your body is treated, and the dose of radiotherapy, so your team will explain which are relevant for you. They start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy.

	Expected 50%–100%	**Common** 10%–50%	**Less common** Less than 10%	**Rare** Less than 1%	**Not applicable to you**
General regardless of site: Tiredness	☐	☐	☐	☐	☐
Skin (in the treated area): Skin soreness, itching, swelling and colour changes*	☐	☐	☐	☐	☐
Localised hair loss	☐	☐	☐	☐	☐
Head and/or neck: Eye: redness, watering or light sensitivity	☐	☐	☐	☐	☐
Mouth: redness, pain, ulceration, dryness or taste change	☐	☐	☐	☐	☐
Throat: pain or hoarse voice	☐	☐	☐	☐	☐
Chest: Pain on or difficulty swallowing	☐	☐	☐	☐	☐
Shortness of breath or cough	☐	☐	☐	☐	☐
Abdomen and/or pelvis: Nausea	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐
Indigestion	☐	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	☐
Urinary frequency (passing urine more often than normal)	☐	☐	☐	☐	☐
Limb: Limb swelling	☐	☐	☐	☐	☐

* ***white/lighter skin:*** *pink, red, darker than surrounding area;* ***brown skin:*** *maroon or darker than surrounding area;* ***black skin:*** *darker than surrounding area, yellow/purple/grey colour changes*

Specific risks to you from your treatment

I confirm that I have had the above side-effects explained. **Patient initials** _____

Patient name: _____ **Patient unique identifier:** _____

Possible late or long-term side-effects

These may happen many months or years after radiotherapy and may be permanent.

	Expected 50%–100%	**Common** 10%–50%	**Less common** Less than 10%	**Rare** Less than 1%	**Not applicable to you**
Skin (in the treated area): Colour change (lighter or darker for any skin tone) and sensitivity to sun and temperature change	☐	☐	☐	☐	☐
Poor hair growth	☐	☐	☐	☐	☐
Head and/or neck: Dry eyes	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐
Dry mouth	☐	☐	☐	☐	☐
Dental problems	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐
Increased risk of stroke	☐	☐	☐	☐	☐
Chest: Increased risk of heart disease, especially angina and heart attack	☐	☐	☐	☐	☐
Increased risk of lung scarring (fibrosis)	☐	☐	☐	☐	☐
Abdomen and/or pelvis: Worsening kidney function	☐	☐	☐	☐	☐
Reduced spleen function, increased risk of infections	☐	☐	☐	☐	☐
Increased risk of diabetes	☐	☐	☐	☐	☐
Infertility	☐	☐	☐	☐	☐
Early menopause	☐	☐	☐	☐	☐
Low testosterone levels	☐	☐	☐	☐	☐
Limb: Joint stiffness	☐	☐	☐	☐	☐
Swelling of the limbs (lymphoedema)	☐	☐	☐	☐	☐
Increased risk of secondary cancer specifically: _____	☐	☐	☐	☐	☐

Specific risks to you from your treatment

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: