The Royal College of Radiologists

Radiotherapy consent form for sarcomas - bone and soft tissue tumours (extremity)

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 and side:	☐ **Specify site:** _____ ☐ **Left** ☐ **Right**
Aim of treatment: (Tick as appropriate)	☐ **Neo-adjuvant** – treatment given before surgery ☐ **Adjuvant** – treatment given after surgery to reduce the risk of cancer coming back ☐ **Definitive** – without surgery ☐ **Palliative** – to improve your symptoms and/or help you live longer but not to cure your cancer
Concurrent systemic anti-cancer therapy (SACT), including chemotherapy: (Tick as appropriate)	☐ **Yes with** _____ Side effects of radiotherapy may be increased when receiving concurrent systemic anti-cancer therapy. A separate consent form will cover the side effects of this treatment. ☐ **No**

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, can peak shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

	Expected 50%–100%	Common 10%–50%	Less common Less than 10%	Rare Less than 1%	Not applicable to you
General radiotherapy risks					
Tiredness	☐	☐	☐	☐	☐
Skin soreness, itch or colour change in the treatment area – **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.	☐	☐	☐	☐	☐
Skin breakdown in the treatment area – oozing, weeping, scabbing and/or bleeding	☐	☐	☐	☐	☐
Hair thinning or loss in the treatment area	☐	☐	☐	☐	☐
Limb oedema – swelling in all or part of the limb due to fluid build-up	☐	☐	☐	☐	☐
Pain – may require pain killers / analgesics	☐	☐	☐	☐	☐
Post-surgical wound complications – which may require dressing, packing, drainage, antibiotics	☐	☐	☐	☐	☐
Post-surgical wound complications –requiring surgery and debridement	☐	☐	☐	☐	☐
Joint stiffness – reduced range of movement experienced over joints and/or muscles	☐	☐	☐	☐	☐
Joint immobility – which may affect how well the joint functions	☐	☐	☐	☐	☐
Tumour growth during pre-operative radiotherapy – which may make surgery more extensive or not possible. This is not a consequence of the radiotherapy.	☐	☐	☐	☐	☐
Specific risks which relate to the site of treatment					
Inflammation of the lungs – which may cause shortness of breath and/or cough	☐	☐	☐	☐	☐
Change in bowel habit – increased frequency (opening your bowels more often than usual), urgency (a sudden urge to open your bowels), incontinence, and/or looser stool with more mucous or wind	☐	☐	☐	☐	☐
Urinary symptoms – increased frequency (passing more urine than usual), urgency (a sudden urge to pass urine), incontinence, discomfort on passing urine, and/or an inability to pass urine (you may require a urinary catheter)	☐	☐	☐	☐	☐

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Possible early or short-term side-effects continued

	Expected 50%–100%	Common 10%–50%	Less common Less than 10%	Rare Less than 1%	Not applicable to you
Rectal and/or anal pain and/or a feeling of not completely emptying your bowels	☐	☐	☐	☐	☐
Vaginal soreness, itching, or discharge	☐	☐	☐	☐	☐

Other 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

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

	Expected 50%–100%	**Common** 10%–50%	**Less common** Less than 10%	**Rare** Less than 1%	**Not applicable to you**
General radiotherapy risks					
Tiredness – chronic fatigue	☐	☐	☐	☐	☐
Permanent skin colour change – usually lighter or darker for any skin tone **and/or texture change** (thicker or thinner skin)	☐	☐	☐	☐	☐
Increased sensitivity of skin to sun	☐	☐	☐	☐	☐
Permanent hair loss in and around treatment area – if hair starts to regrow, it may be patchy	☐	☐	☐	☐	☐
Small visible blood vessels which look like spidery marks in the treatment area	☐	☐	☐	☐	☐
Long-term pain – may require pain killers	☐	☐	☐	☐	☐
Chronic muscle wasting – decrease in size and wasting of muscle tissue	☐	☐	☐	☐	☐
Lymphoedema – swelling in all or part of the limb due to fluid (lymph) build-up	☐	☐	☐	☐	☐
Soft tissue fibrosis – scarring or hardening of the skin, muscle, fat, fibrous tissue	☐	☐	☐	☐	☐
Joint stiffness – reduced range of movement experienced over joints and/or muscles	☐	☐	☐	☐	☐
Joint immobility – which may affect how well the joint functions	☐	☐	☐	☐	☐
Delayed wound healing	☐	☐	☐	☐	☐
Insufficiency fracture – a fracture that develops in the bone within the treatment area	☐	☐	☐	☐	☐
Bone infarction/osteonecrosis – death of bone caused by poor blood supply within the treatment area	☐	☐	☐	☐	☐
Nerve damage – which may cause pain, numbness, or weakness in the limb	☐	☐	☐	☐	☐
Radiation-induced necrosis/ulceration – radiation exposure kills or leads to the death of the soft tissue over the treatment area / tissue is unable to heal leaving an open sore	☐	☐	☐	☐	☐
Secondary amputation – surgery to remove the limb	☐	☐	☐	☐	☐
Increased risk of a different cancer in the treatment area	☐	☐	☐	☐	☐

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

Possible late or long-term side-effects continued

	Expected 50%–100%	Common 10%–50%	Less common Less than 10%	Rare Less than 1%	Not applicable to you
Specific risks which relate to the site of treatment					
Lung fibrosis (scarring) – which may cause breathlessness and/or chronic cough	☐	☐	☐	☐	☐
Change in bowel habit – increased frequency (opening your bowels more often than usual), urgency (a sudden urge to open your bowels), incontinence, and/or looser stool with more mucous or wind	☐	☐	☐	☐	☐
Rectal or anal pain – this may cause pain when opening your bowels and may affect your sex life if you receive anal sex	☐	☐	☐	☐	☐
Bleeding from your bladder or bowel	☐	☐	☐	☐	☐
Urinary symptoms – increased frequency (passing more urine than usual), urgency (a sudden urge to pass urine), incontinence, discomfort on passing urine, and/or an inability to pass urine (you may require a urinary catheter)	☐	☐	☐	☐	☐
Vaginal dryness, shortening and narrowing – this may impact vaginal intercourse. You may be advised to use vaginal dilators after treatment to reduce risks	☐	☐	☐	☐	☐
Infertility – unable to produce viable egg/sperm, or for uterus to be unable to carry a fetus	☐	☐	☐	☐	☐
Early menopause – symptoms of this may start during or shortly after radiotherapy. Egg and hormone production will stop	☐	☐	☐	☐	☐
Low testosterone levels	☐	☐	☐	☐	☐
Erectile dysfunction	☐	☐	☐	☐	☐
Other 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 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: