The Royal College of Radiologists

Radiotherapy consent form – brachytherapy for gynaecologic cancer

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:	**Internal radiotherapy (brachytherapy)**
Site: (Tick as appropriate)	☐ **Cervix** ☐ **Uterus (womb)** ☐ **Vaginal vault** ☐ **Vagina** ☐ **Vulva**
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured ☐ **Adjuvant** – treatment given after surgery to reduce the risk of cancer coming back ☐ **Disease control/palliative** – to improve your symptoms and/or help you live longer 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

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%

- ☐ **Tiredness**
- ☐ **Mild pelvic pain**
- ☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Bowel frequency** (opening your bowels more often than normal) and **urgency** (a sudden urge to open your bowels)
- ☐ **Vaginal itching, discharge or light bleeding (spotting)**
- ☐ **Discomfort from prolonged bed rest**

Common
10%–50%

- ☐ **Cystitis/pain when you urinate**
- ☐ **Urinary incontinence** – including urine leaking when coughing or straining
- ☐ **Rectal pain/discomfort**

Less common
Less than 10%

- ☐ **Looser stools** compared to normal
- ☐ **Skin soreness, itching, blistering and colour changes** – redness in white skin tones and subtle darkening, yellow/purple/grey appearance in brown and black skin tones
- ☐ **Uterine/vaginal perforation** – caused by instrumentation at the time of the procedure
- ☐ **Bleeding from your bladder or bowel**
- ☐ **Moderate pelvic pain**

Rare
Less than 1%

- ☐ **Heavy bleeding** – which may need further treatment or surgery
- ☐ **Infection**
- ☐ **Risk of developing a symptomatic blood clot**
- ☐ **Perforation of the bowel/bladder** – caused by instrumentation at the time of the procedure
- ☐ **Risk of developing a pressure sore**

Important information

Complications of treatment can very occasionally be life threatening and may result in death. The risks are different for every individual. Potentially life threatening complications include those listed on this form, but, other, exceedingly rare side effects may also be life threatening.

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. Many of these late side effects, taken in combination, are often referred to as pelvic radiation disease.

Definite
100%

This is important. If the uterus (womb) and/or ovaries are in the treatment field, please let us know about your plans for having children and we can advise accordingly.

- ☐ **Early menopause** – symptoms of this may start during or shortly after radiotherapy
- ☐ **Infertility** – you will be unable to carry a pregnancy in the uterus (womb) after radiotherapy, but you must use contraception when having vaginal sex during radiotherapy. Egg and hormone production will stop.

Expected
50%–100%

- ☐ **Vaginal narrowing, shortening or dryness** – this may impact vaginal intercourse, and the comfort and quality of a vaginal examination. You may be advised to use vaginal dilators after treatment which may reduce this risk.

Common
10%–50%

- ☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Urinary incontinence** – including urine leaking when coughing or straining
- ☐ **Bowel frequency** (opening your bowels more often than normal) and **urgency** (a sudden urge to open your bowels)
- ☐ **Looser stools** compared to normal

Less common
Less than 10%

- ☐ **Cystitis/pain when you urinate**
- ☐ **Rectal pain/discomfort** – which may worsen on opening your bowels. This may also affect your sex life if you receive anal sex.
- ☐ **Bleeding from your bladder, bowel or vagina**
- ☐ **Bowel/bladder damage which may require surgery** – due to stricture (narrowing), fistula (abnormal connection between two parts of your body) and may require stoma formation.

Rare
Less than 1%

- ☐ **A different cancer in the treatment area**

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 foetus. 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.

Signature:

Patient name:

Date:

Use of General/Spinal Anaesthesia and procedural sedation

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health. I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

Signature:

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:

