The Royal College of Radiologists

Palliative radiotherapy consent form

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

Treatment site: (Specify left or right side as appropriate)	
Number of treatments (fractions): (optional) This can include a range	
Aim of treatment: (Tick as appropriate)	**The aim of palliative radiotherapy is not to cure but rather:** ☐ **To improve / alleviate the symptoms caused by the tumour** **Specify symptoms:** ☐ **To control the cancer in the treated area by shrinking or halting the growth of the tumour**

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:** _____

Side-effects of treatment

Side effects of treatment vary from patient to patient. Early or short term side effects are common and improve gradually over a period of weeks after the treatment is completed. Frequencies are approximate.

	Expected 50%–100%	**Common** 10%–50%	**Less common** Less than 10%	**Not applicable to you**
Fatigue	☐	☐	☐	☐
Symptom flare (e.g. pain)	☐	☐	☐	☐
Localised skin reaction (soreness and colour changes - redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones)	☐	☐	☐	☐
Hair loss in the treatment area (temporary/permanent)	☐	☐	☐	☐
Headache	☐	☐	☐	☐
Cough	☐	☐	☐	☐
Difficulty in swallowing / indigestion	☐	☐	☐	☐
Nausea / sickness	☐	☐	☐	☐
Change in bowel habit	☐	☐	☐	☐
Change in urinary function	☐	☐	☐	☐
Other side effects that may result from your specific treatment include:				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

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 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:

