Radiotherapy consent form for breast cancer

Clinical Oncology
The Royal College of Radiologists

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 radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy treatment

Radiotherapy type: External beam radiotherapy

Site and side:
(Tick as appropriate)

R = Right / L = Left

☐ Breast	☐ R	☐ L
☐ Partial breast	☐ R	☐ L
☐ Chest wall	☐ R	☐ L
☐ Lymph nodes in armpit (axilla)	☐ R	☐ L
☐ Lymph nodes in lower neck (supraclavicular fossa)	☐ R	☐ L
☐ Lymph nodes behind the breastbone (internal mammary chain)	☐ R	☐ L
☐ Tumour bed boost	☐ R	☐ L
☐ Other _____	☐ R	☐ L

Aim of treatment:
(Tick as appropriate)

- ☐ **Curative** – to give you the best chance of being cured
- ☐ **Neo-adjuvant** – treatment given before surgery to shrink the tumour
- ☐ **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** ☐ **Temporary hair loss in treatment area**
Common 10%–50%	☐ **Skin soreness, redness and itching in the treatment area**
Less common Less than 10%	☐ **Breast/chest wall/axilla discomfort** ☐ **Breast swelling** ☐ **Change in breast texture**
Rare Less than 1%	☐ **Sore throat** ☐ **Skin blistering** ☐ **Pneumonitis** – temporary inflammation of the lung leading to cough/breathlessness
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%

- ☐ **Skin colour change in the treatment area including:**
  – Lighter, darker or pinker
- ☐ **Subtle changes to breast appearance including:**
  – Change to breast size, shape and texture
- ☐ **Breast/chest wall/axilla discomfort including:**
  – Aching and shooting pains
- ☐ **Worsened cosmetic outcome after reconstruction surgery** – which may require the implant to be replaced

Less common
Less than 10%

- ☐ **Marked change to breast appearance including:**
  – Change to breast size, shape and texture
- ☐ **Breast/chest wall swelling**
- ☐ **Shoulder stiffness**
- ☐ **Lymphoedema of the arm** – fluid collecting in the arm which may cause swelling, pain and or movement difficulties

Rare
Less than 1%

- ☐ **Telangiectasia in the treatment area** – small visible blood vessels which look like spidery marks
- ☐ **Rib fracture**
- ☐ **Fibrosis (scarring) of the underlying lung** – which can cause breathlessness, cough or changes on X-ray
- ☐ **Increased risk of heart disease in later life**
- ☐ **Brachial plexopathy** – nerve damage which may cause pain, numbness or tingling affecting the arm and shoulder
- ☐ **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 fetus.

☐ 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: _____

