Radiotherapy consent form – gynaecologic 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)	☐ **Pelvis** ☐ **Vulva/perineum** ☐ **Groin (inguinal) lymph nodes** **Left** ☐ **Right** ☐ **Bilateral** ☐ ☐ **Abdominal (para-aortic) lymph nodes**
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
Concurrent systemic anti-cancer therapy: (Tick as appropriate)	☐ **Yes with** _____ ☐ **No** (A separate consent form will cover the possible side-effects of this treatment)

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.

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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**
- ☐ **Bowel frequency** (opening your bowels more often than normal) and **urgency** (a sudden urge to open your bowels)
- ☐ **Looser stools** with more mucous or wind compared to normal
- ☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Hair loss in treatment area**
- ☐ **Radiotherapy to the abdomen:**
  - **Nausea and/or vomiting**
- ☐ **Radiotherapy to the lower pelvis/vulva:**
  - **Skin soreness, itching, redness and breakdown**
  - **Pain from the skin on passing urine and opening bowels**
  - **Rectal pain/discomfort**
  - **Vaginal itching or discharge**

Common
10%–50%

- ☐ **Skin soreness, itching and redness**
- ☐ **Pain from the skin on passing urine and opening bowels**
- ☐ **Cystitis/pain when you urinate**

Less common
Less than 10%

- ☐ **Rectal pain/discomfort**
- ☐ **Vaginal itching or discharge**
- ☐ **Decreased blood counts** – causing anaemia, bleeding or risk of infection

Rare
Less than 1%

- ☐ **Bleeding from your bladder or bowel**

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.

Definite
100%

This is important. If your 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. Egg and hormone production will stop.
- ☐ **Infertility** – you will be unable to carry a pregnancy in your uterus (womb) after radiotherapy, but you must use contraception during radiotherapy

Expected
50%–100%

- ☐ **Vaginal narrowing, shortening or dryness** – this may impact on sexual function and comfort during 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
- ☐ **Asymptomatic pelvic bone fractures** particularly in post-menopausal women
- ☐ **Radiotherapy to the lower pelvis/vulva**
  - **Hair loss** in treatment area
  - **Lymphoedema** – (fluid build-up) in your legs or pubic area
  - **Skin thickening or discoloration** lighter, darker or visible blood vessels
  - **Skin thinning**

Less common
Less than 10%

- ☐ **Cystitis/pain when you urinate**
- ☐ **Reduced bladder capacity**
- ☐ **Rectal pain/discomfort**
- ☐ **Faecal discharge/soiling**
- ☐ **Bleeding from your bladder or 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
- ☐ **Duodenal ulceration**
- ☐ **Symptomatic pelvic bone fractures** particularly in post-menopausal women
- ☐ **Kidney impairment**
- ☐ **Malabsorption** – problems with nutrient absorption
- ☐ **Hair loss in treatment area**
- ☐ **Lymphoedema** – (fluid build-up) in your legs or pubic area

Rare
Less than 1%

- ☐ **Skin thickening or discoloration** lighter, darker or visible blood vessels
- ☐ **Urinary strictures** – narrowing of tubes running from kidneys and bladder
- ☐ **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** _____

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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.

☐ 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:

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