Radiotherapy consent form for head and neck cancer (lower sites)

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)

- ☐ Oral cavity
- ☐ Oropharynx
- ☐ Larynx
- ☐ Hypopharynx
- ☐ Other

Radiotherapy to the neck

- ☐ Left
- ☐ Right
- ☐ Bilateral (both sides)

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.

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

Possible early or 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**
- ☐ **Skin soreness, redness, blistering and itching in the treatment area**
- ☐ **Thickened and tenacious secretions**
- ☐ **Dry mouth**
- ☐ **Oral ulcers**
- ☐ **Pain in the mouth and/or throat** which can cause problems with swallowing
- ☐ **Loss or change of taste**
- ☐ **Voice changes**
- ☐ **Cough**
- ☐ **Loss of appetite**
- ☐ **Hair loss in treatment area**
- ☐ **Anxiety, low mood, feeling fed-up or poor sleep**

Common
10%–50%

- ☐ **Blocked ear and/or earache**
- ☐ **Mouth infections** including oral thrush
- ☐ **Nausea** – feeling sick
- ☐ **Vomiting**
- ☐ **Difficulty swallowing** which may require temporary placement of a feeding tube at the start of treatment or during treatment to support nutrition and hydration

Less common
Less than 10%

- ☐ **Chest infection** which may be due to food and/or secretions going down the windpipe
- ☐ **Dehydration** as a result of reduced oral intake
- ☐ **Swelling of voice box** – laryngeal oedema
- ☐ **Risk of hospital admission**
- ☐ **Lhermitte's sign** – temporary changes to the spinal cord presenting as a sudden electric shock like sensation on bending the neck, may occur three to six months after treatment

Rare
Less than 1%

- ☐ **Risk to life**

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%

- ☐ **Skin colour change in the treatment area** – usually lighter or darker
- ☐ **Lymphoedema** – skin, chin and soft-tissue swelling
- ☐ **Dry mouth**
- ☐ **Altered taste or loss of taste** – with possibility of some recovery over 18 months
- ☐ **Hair loss in the treatment area or patchy re-growth**

Common
10%–50%

- ☐ **Permanent skin texture changes in treatment area** – thicker or thinner skin
- ☐ **Telangiectasia in the treatment area** – small visible blood vessels which look like spidery marks
- ☐ **Dental problems**
- ☐ **Trismus** – jaw stiffness
- ☐ **Voice changes**
- ☐ **Hypothyroidism** – under-active thyroid gland, which may require you to take medication

Less common
Less than 10%

- ☐ **Hearing loss or changes**
- ☐ **Osteoradionecrosis of the jaw** – damage to the jawbone
- ☐ **Swallowing problems** with risk of long-term/permanent feeding tube requirement
- ☐ **Laryngeal chondronecrosis** – irreversible damage to the voice box
- ☐ **Increased risk of stroke**

Rare
Less than 1%

- ☐ **Permanent changes to brainstem, spinal cord and nerves to the face, arm or hand**
- ☐ **A different cancer in the treatment area**
- ☐ **Risk to life**

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: _____

