

Radiotherapy consent form for oesophageal 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:

Oesophagus

Aim of treatment:
(Tick as appropriate)

- Curative** – to give you the best chance of being cured
- Neo-adjuvant** – treatment given before surgery
- 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% 	<input type="checkbox"/> Tiredness <input type="checkbox"/> Skin soreness, redness and itching in the treatment area <input type="checkbox"/> Increased saliva or mucous production <input type="checkbox"/> Loss of appetite which may lead to weight loss <input type="checkbox"/> Inflammation of the oesophagus which may cause pain and/or difficulty with swallowing <input type="checkbox"/> Indigestion or heartburn <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Abdominal discomfort or bloating
Common 10%–50% 	<input type="checkbox"/> Hair loss in treatment area <input type="checkbox"/> Inflammation of the lungs – causing cough or shortness of breath <input type="checkbox"/> Feeding via a tube into the stomach/small intestine <input type="checkbox"/> Admission to hospital for control of side-effects <input type="checkbox"/> Sore mouth or throat
Less common Less than 10% 	<input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Change in voice
Rare Less than 1% 	<input type="checkbox"/> Risk of an oesophageal fistula – abnormal connection between the oesophagus and airways <input type="checkbox"/> Pneumonia
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% 	<input type="checkbox"/> Ongoing fatigue <input type="checkbox"/> Oesophageal stricture which may require endoscopic treatment <input type="checkbox"/> Oesophageal dysmotility causing a change in swallow <input type="checkbox"/> Fibrosis (scarring) of the underlying lung which can cause breathlessness, cough or changes on X-ray
Less common Less than 10% 	<input type="checkbox"/> Hypothyroidism – a hormone deficiency, this may require you to take medications <input type="checkbox"/> Risk of damage to the heart – risk depends on the position of the tumour in the oesophagus <input type="checkbox"/> Skin changes in treatment area including: – Altered colour usually lighter or darker – Scarring – Telangiectasia – small visible blood vessels which look like spidery marks
Rare Less than 1% 	<input type="checkbox"/> Oesophageal or gastric ulceration or perforation (tear) which may require surgery <input type="checkbox"/> Oesophageal fistulation – abnormal connection between the oesophagus and airways <input type="checkbox"/> Long-term need for feeding via a tube <input type="checkbox"/> Bleeding which may require endoscopic treatment or surgery <input type="checkbox"/> Myelitis – inflammation of nerves which may cause a change in muscle power or sensation <input type="checkbox"/> Risk of rib/vertebral fracture <input type="checkbox"/> Hyposplenism – the spleen no longer functions which lowers immunity and may require additional vaccinations and prophylactic antibiotics <input type="checkbox"/> Long-term decline in kidney function <input type="checkbox"/> A different cancer in the treatment area <input type="checkbox"/> Risk to life
Specific risks to you from your treatment	
	<p>I confirm that I have had the above side-effects explained.</p> <p>Patient initials <input type="text"/></p>

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: