Patient full name.................................................................................................................. Consent Form 3
Hospital number................................................................................................................

Patient agreement to Radiotherapy
You have the right to change your mind at any time including after you have signed this form

Treatment Area ....................................................................................................................

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)
I have explained the procedure to the patient/parent. In particular, I have explained:

The intended benefits:
Improved survival [ ] Improved local control [ ] Symptom control [ ]

Serious or frequently occurring side effects:
Nausea [ ] Tiredness [ ] Poor appetite [ ] Skin reaction [ ]

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

Previous radiotherapy? YES [ ] NO [ ]
Pacemaker fitted? YES [ ] NO [ ]

Patient advised not to become pregnant during radiotherapy? YES [ ] NO [ ] N/A [ ]

The following leaflet/tape has been provided

(Include version number)

I confirm that any exposure to radiation that forms part of the planning and treatment process has been fully justified by myself and duly authorised.

Signed ____________________________ Date ____________________________
Name (PRINT) ____________________________ Job title ____________________________

Special Requirements

Statement of interpreter (where appropriate) N/A [ ]
I have interpreted the information above to the patient/guardian to the best of my ability and in a way in which I believe s/he can understand.

Signed ____________________________ Date ____________________________
Name (PRINT) ____________________________
BRAIN RADIOTHERAPY SIDE EFFECT CHECKLIST

I confirm that I have had explained to me the following ticked side effects, that I may possibly experience, in relation to radiotherapy treatment to the brain area.

Possible late side effects

Sore / itchy scalp ...........................................................................................................................................................................☐
Scalp slightly swollen in treatment area ..................................................................................................................................................☐
Hair loss............................................................................................................................................................................................☐
Temporary increase in headaches ............................................................................................................................................................................☐
Severe tiredness / sleepiness .............................................................................................................................................................................☐

Possible late side effects

Permanent hair loss..................................................................................................................................................................................................................................☐
Hair may grow back slightly different colour .......................................................................................................................................................☐
Hair may grow back different texture ..........................................................................................................................................................☐
Increased chance of epilepsy ..............................................................................................................................................................................................☐

Statement of patient

I agree to the procedure described above.
I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

Signature ___________________________ Date ________________

Name (PRINT) ________________________________________________________________________________________________

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient/guardian has signed the form in advance).

I have confirmed that the patient/guardian has no further questions and wishes the procedure to go ahead.

Signature ___________________________ Date ________________

Name (PRINT) ________________________________________________________________________________________________  Job title ___________________________

White Copy - To be retained in patient’s notes    Blue Copy - GP
Yellow Copy - Given to patient