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

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) ___________________________

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 ___________________________

HEAD AND NECK RADIOThERAPY SIDE EFFECT CHECKLIST

Possible early side effects
Difficulty swallowing ☐
Dryness of mouth ☐
White patches in mouth (thrush) ☐
Production of thick saliva or mucous ☐
Sore throat ☐
Hoarseness / loss of voice ☐
Temporary hearing difficulties ☐
Patchy hair loss in treatment area ☐

Possible late side effects
Discolouration of skin in treated area ☐
Scarring of underlying structures ☐
Reduction of saliva production ☐
Swelling under chin ☐
Difficulty opening mouth (trismus) ☐
Increased dental decay / infection ☐
Bone damage ☐

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 head and neck area.

Difficulty swallowing ☐
Dryness of mouth ☐
White patches in mouth (thrush) ☐
Production of thick saliva or mucous ☐
Sore throat ☐
Hoarseness / loss of voice ☐
Temporary hearing difficulties ☐
Patchy hair loss in treatment area ☐

Discolouration of skin in treated area ☐
Scarring of underlying structures ☐
Reduction of saliva production ☐
Swelling under chin ☐
Difficulty opening mouth (trismus) ☐
Increased dental decay / infection ☐
Bone damage ☐

Form No: 1009

White Copy - To be retained in patient's notes  Blue Copy - GP  Yellow Copy - To be given to patient