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

Treatm ent 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) _______________________________
GYN AECOLOGICAL EXTERNAL BEAM PELVIC RADIOTHERAPY / HDR BRACHYTHERAPY SIDE EFFECTS CHECKLIST

I confirm that I have had explained to me the following ticked side effects, that I may possibly experience, in relation to receiving the following treatment(s).

External beam gynae pelvic radiotherapy treatment .................................................................
HDR (high dose rate) gynae brachytherapy treatment .............................................................

Possible early side effects
- Pain passing water (cystitis) ........................................................................................................
- Need to pass water more often ....................................................................................................
- Bleeding / discharge from vagina .................................................................................................
- Sore back passage .........................................................................................................................
- Diarrhoea .......................................................................................................................................
- Soreness of skin and mucous membranes vulval & vaginal areas ..............................................

Possible late side effects
- Early menopause ........................................................................................................................
- Minor bowel changes ...................................................................................................................
- Minor bladder changes ...............................................................................................................?
- Scarring / narrowing of vagina ....................................................................................................
- Dryness of vagina ........................................................................................................................

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 - To be given to patient