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

Treatment area including treatment site (laterality):

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

The patient/guardian has confirmed identity: YES ☐ Using passport/driving licence: YES ☐

The patient/guardian has confirmed treatment site (laterality): YES ☐

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 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) _______________________________
RADIONTHERAPY TO THE BREAST 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 to the breast.

Possible late side effects

Breast swelling .................................................................
Fibrosis / shrinkage ...........................................................
Skin changes ..................................................................
Chest wall tenderness .....................................................
Swelling of the arm (Lymphoedema) .................................

Rare late side effects

Lung scarring ..................................................................
Effects on the heart ........................................................
Cancers caused by the treatment ......................................

Other late side effects ........................................................
................................................................................................
................................................................................................

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