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)

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

(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) ___________________________
IMAGINE GUIDED EXTERNAL BEAM RADIOTHERAPY/HIGH DOSE RATE BRACHYTHERAPY TREATMENT TO THE PROSTATE

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):

Imaging guided external beam radiotherapy treatment to the prostate  
High dose rate brachytherapy treatment to the prostate

Possible early side effects

- Pain on passing water (urine)
- Passing urine more often, day and night
- Passing blood in urine
- Diarrhoea
- Passing blood and mucous through back passage (rectum)
- Pain / discomfort in the anal region

Possible late side effects

- Minor bowel changes
- Bowel changes, possibly requiring surgery
- Second cancer
- Infertility
- Impotence
- Incontinence (stool and urine)
- Pubic hair loss
- Damage to bladder and urethra

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 ____________________