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 ☐

Other additional side effects:

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:  ☐ YES  ☐ NO
If YES, please state:

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.

I understand that the procedure will/will not involve local anaesthesia.

Signature  __________________________  Date  __________________________
Name (PRINT)  __________________________  Relationship to patient  __________________________

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)  __________________________

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  __________________________