

Radiotherapy consent form for breast cancer



Clinical
Oncology

The Royal College of Radiologists

This form should only be used if the patient is over 18 years old and has capacity to give consent. If the patient does not legally have capacity please use an appropriate alternative consent form from your hospital.

Patient details

Patient name:

Date of birth:

Patient unique identifier:

Name of hospital:

Responsible consultant oncologist or consultant radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy treatment

Radiotherapy treatment:	External beam radiotherapy
Site and side: (Tick as appropriate) R = Right / L = Left	<input type="checkbox"/> Breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Partial breast <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Chest wall <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lymph nodes in armpit (axilla) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lymph nodes in lower neck (supraclavicular fossa) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Lymph nodes behind the breastbone (internal mammary chain) <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Tumour bed boost <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other <input type="checkbox"/> R <input type="checkbox"/> L
Aim of treatment: (Tick as appropriate)	<input type="checkbox"/> Curative – to give you the best chance of being cured <input type="checkbox"/> Neo-adjuvant – treatment given before surgery to shrink the tumour <input type="checkbox"/> Adjuvant – treatment given after surgery to reduce the risk of cancer coming back <input type="checkbox"/> Disease control/palliative – to help you live longer but not to cure the cancer <input type="checkbox"/> Disease control/palliative – to improve your symptoms but not to cure the cancer

You may have questions before starting, during or after your radiotherapy.

Contact details are provided here for any further queries, concerns or if you would like to discuss your treatment further.

Patient confirmation of consent

(To be signed prior to the start of radiotherapy)

I confirm that I have no further questions and wish to go ahead with treatment.

Signature:

Date:

Additional considerations

(where appropriate)

Patient name:

Patient name:

Patient unique identifier:

Possible early/short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected 50%–100% 	<input type="checkbox"/> Tiredness <input type="checkbox"/> Temporary hair loss in treatment area
Common 10%–50% 	<input type="checkbox"/> Skin soreness, redness and itching in the treatment area
Less common Less than 10% 	<input type="checkbox"/> Breast/chest wall/axilla discomfort <input type="checkbox"/> Breast swelling <input type="checkbox"/> Change in breast texture
Rare Less than 1% 	<input type="checkbox"/> Sore throat <input type="checkbox"/> Skin blistering <input type="checkbox"/> Pneumonitis – temporary inflammation of the lung leading to cough/breathlessness
Specific risks to you from your treatment	

I confirm that I have had the above side-effects explained.

Patient initials

Patient name:

Patient unique identifier:

Possible late or long-term side-effects

May happen many months or years after radiotherapy and may be permanent.
Frequencies are approximate.

Expected 50%–100% 	
Common 10%–50% 	<input type="checkbox"/> Skin colour change in the treatment area including: – Lighter, darker or pinker <input type="checkbox"/> Subtle changes to breast appearance including: – Change to breast size, shape and texture <input type="checkbox"/> Breast/chest wall/axilla discomfort including: – Aching and shooting pains <input type="checkbox"/> Worsened cosmetic outcome after reconstruction surgery – which may require the implant to be replaced
Less common Less than 10% 	<input type="checkbox"/> Marked change to breast appearance including: – Change to breast size, shape and texture <input type="checkbox"/> Breast/chest wall swelling <input type="checkbox"/> Shoulder stiffness <input type="checkbox"/> Lymphoedema of the arm – fluid collecting in the arm which may cause swelling, pain and or movement difficulties
Rare Less than 1% 	<input type="checkbox"/> Telangiectasia in the treatment area – small visible blood vessels which look like spidery marks <input type="checkbox"/> Rib fracture <input type="checkbox"/> Fibrosis (scarring) of the underlying lung – which can cause breathlessness, cough or changes on X-ray <input type="checkbox"/> Increased risk of heart disease in later life <input type="checkbox"/> Brachial plexopathy – nerve damage which may cause pain, numbness or tingling affecting the arm and shoulder <input type="checkbox"/> A different cancer in the treatment area – not related to your current cancer, which may occur many years after treatment
Specific risks to you from your treatment	
I confirm that I have had the above side-effects explained.	
	Patient initials

Patient name:

Patient unique identifier:

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure)

- I have discussed what the treatment is likely to involve, the intended aims and side-effects of this treatment.
- I have also discussed the benefits and risks of any available alternative treatments including no treatment.
- I have discussed any particular concerns of this patient.

Patient information leaflet provided: Yes / No – Details: _____

Copy of consent form accepted by patient: Yes / No

Signature:

Date:

Name:

Job title:

Statement of patient

Please read this form carefully. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

- I agree to the course of treatment described on this form.
 - I have had the aims and possible side-effects of treatment explained to me.
 - I have had the opportunity to discuss treatment alternatives, including no treatment.
 - I understand that a guarantee cannot be given that a particular person will perform the radiotherapy. The person will, however, have appropriate expertise.
 - I understand that scans are for planning and checking my treatment only, not for diagnostic purposes.
 - I have been told about additional procedures which are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks and photographs to help with treatment planning and identification.
- I understand that information collected during my radiotherapy treatment, including images, may be used for education, audit and research (which may be published in medical journals). All information will be anonymised and used in a way that I cannot be identified. Please contact your radiotherapy department if you wish to withdraw consent for information use in this way.
- I agree that my health records may be used by authorised members of staff, who are not directly involved in my clinical care, for research approved by a research ethics committee and in compliance with the Data Protection Act (2018).

Tick if relevant

- I confirm that there is no risk that I could be pregnant.
- I understand that I should not become pregnant during treatment.

Note: if there is any possibility of you being pregnant you must tell your hospital doctor/health professional before your treatment as this can cause significant harm to an unborn fetus.

- I do not have a pacemaker and/or implantable cardioverter defibrillator (ICD).
- or**
- I have a pacemaker and/or implantable cardioverter defibrillator (ICD) and I have had the risks associated with this explained to me.

Signature:

Date:

Patient name:

Statement of interpreter/witness

(where appropriate)

- I have interpreted the information contained in this form to the patient to the best of my ability and in a way in which I believe they can understand.
- or**
- I confirm that the patient is unable to sign but has indicated their consent.

Signature:

Name:

Date:

Job title/role: