

# Radiotherapy consent form for lung cancer (SABR)



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:

Stereotactic ablative body radiotherapy (SABR) to the thorax for peripheral or central lung tumours (not ultra-central tumours) as defined by the UK SABR consortium

Site and side:

(Tick as appropriate)

- Left lung  
 Right lung  
 Bilateral (both sides)

Aim of treatment:

(Tick as appropriate)

- Curative – to give you the best chance of being curedd  
 Neo-adjuvant – treatment given before surgery  
 Adjuvant – treatment given after surgery to reduce the risk of cancer coming back  
 Disease control/palliative – to help you live longer but not to cure the cancer  
 Disease control/palliative – to improve your symptoms but not to cure the cancer

Concurrent systemic anti-cancer therapy:

(Tick as appropriate)

- Yes with \_\_\_\_\_  
 No

(A separate consent form will cover the possible side-effects of this treatment)

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 or 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.

<b>Expected</b> 50%–100% 	<input type="checkbox"/> Tiredness
<b>Common</b> 10%–50% 	<input type="checkbox"/> Mild, temporary shortness of breath and cough <input type="checkbox"/> Chest wall and/or rib pain <input type="checkbox"/> Mild nausea – feeling sick <input type="checkbox"/> Inflammation of the lung which can cause changes on your X-ray
<b>Less common</b> Less than 10% 	<input type="checkbox"/> Shortness of breath or cough (moderate to severe) which can affect day-to-day life and is caused by pneumonitis (temporary inflammation of the lungs) <input type="checkbox"/> Skin soreness, redness and itching in the treatment area
<b>Rare</b> Less than 1% 	<input type="checkbox"/> Coughing-up small amounts of blood <input type="checkbox"/> Risk to life – very rare
<b>Specific risks to you from your treatment</b>	

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.

<b>Expected</b> 50%–100% 	<input type="checkbox"/> <b>Lung fibrosis</b> – scarring of the lung which can be seen on an X-ray or computed tomography (CT) scan which usually does not cause a significant increase in breathlessness
<b>Common</b> 10%–50% 	
<b>Less common</b> Less than 10% 	<input type="checkbox"/> <b>Long-term shortness of breath or cough</b> caused by fibrosis (scarring) of the lung which can be seen on an X-ray or CT scan <input type="checkbox"/> <b>Mild to moderate chest wall/rib pain</b> <input type="checkbox"/> <b>More prone to rib fractures in radiotherapy treatment area</b> <input type="checkbox"/> <b>Risk of damage to the nerves to the arms/hands</b> which can cause pain, numbness or tingling sensations <input type="checkbox"/> <b>Risk of damage to the heart</b> – risk depends on the position of the tumour
<b>Rare</b> Less than 1% 	<input type="checkbox"/> <b>Airway narrowing or risk of bleeding from airways</b> <input type="checkbox"/> <b>A different cancer in the treatment area</b> – not related to your current cancer, which may occur many years after treatment <input type="checkbox"/> <b>Risk to life</b> – very rare
<b>Specific risks to you from your treatment</b>	
	<b>I confirm that I have had the above side-effects explained.</b>
	<b>Patient initials</b> 

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).

## 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:

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: