Radiotherapy consent form for oesophageal 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:	**Oesophagus**
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured ☐ **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:

Patient name:

Additional considerations

(where appropriate)

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.

Expected
50%–100%

- ☐ **Tiredness**
- ☐ **Skin soreness, redness and itching in the treatment area**
- ☐ **Increased saliva or mucous production**
- ☐ **Loss of appetite** which may lead to weight loss
- ☐ **Inflammation of the oesophagus** which may cause pain and/or difficulty with swallowing
- ☐ **Indigestion or heartburn**
- ☐ **Nausea or vomiting**
- ☐ **Abdominal discomfort or bloating**

Common
10%–50%

- ☐ **Hair loss in treatment area**
- ☐ **Inflammation of the lungs** – causing cough or shortness of breath
- ☐ **Feeding via a tube into the stomach/small intestine**
- ☐ **Admission to hospital** for control of side-effects
- ☐ **Sore mouth or throat**

Less common
Less than 10%

- ☐ **Mouth ulcers**
- ☐ **Change in voice**

Rare
Less than 1%

- ☐ **Risk of an oesophageal fistula** – abnormal connection between the oesophagus and airways
- ☐ **Pneumonia**

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%

- ☐ **Ongoing fatigue**
- ☐ **Oesophageal stricture** which may require endoscopic treatment
- ☐ **Oesophageal dysmotility** causing a change in swallow
- ☐ **Fibrosis (scarring) of the underlying lung** which can cause breathlessness, cough or changes on X-ray

Less common
Less than 10%

- ☐ **Hypothyroidism** – a hormone deficiency, this may require you to take medications
- ☐ **Risk of damage to the heart** – risk depends on the position of the tumour in the oesophagus
- ☐ **Skin changes in treatment area including:**
  - Altered colour usually lighter or darker
  - Scarring
  - Telangiectasia – small visible blood vessels which look like spidery marks

Rare
Less than 1%

- ☐ **Oesophageal or gastric ulceration or perforation (tear)** which may require surgery
- ☐ **Oesophageal fistulation** – abnormal connection between the oesophagus and airways
- ☐ **Long-term need for feeding via a tube**
- ☐ **Bleeding** which may require endoscopic treatment or surgery
- ☐ **Myelitis** – inflammation of nerves which may cause a change in muscle power or sensation
- ☐ **Risk of rib fracture** after an injury
- ☐ **Hyposplenism** – the spleen no longer functions which lowers immunity and may require additional vaccinations and prophylactic antibiotics
- ☐ **Long-term decline in kidney function**
- ☐ **A different cancer in the treatment area** – not related to your current cancer, which may occur many years after treatment
- ☐ **Risk to life**

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: