Radiotherapy consent form for prostate 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: (Tick as appropriate)	☐ **Prostate/seminal vesicles** ☐ **Prostate bed** ☐ **Pelvic lymph nodes** ☐ **Other (please specify)**
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured ☐ **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

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/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**
- ☐ **Urinary symptoms including:**
  - Frequency: passing urine more often than normal
  - Urgency: a sudden urge to pass urine
  - Slower urinary flow compared to normal

Common
10%–50%

- ☐ **Hair loss in the treatment area**
- ☐ **Bowel symptoms including:**
  - Frequency: opening your bowels more often than normal
  - Urgency: a sudden urge to open your bowels
  - Looser stools compared to your usual
  - Passing more mucous or wind compared to what is normal for you

Less common
Less than 10%

- ☐ **Skin redness/irritation in the treatment area**
- ☐ **Urinary symptoms including:**
  - Cystitis/pain/discomfort when you urinate: due to bladder inflammation
- ☐ **Bowel symptoms including:**
  - Rectal pain/discomfort – due to rectal inflammation
  - A feeling of not completely emptying your bowels
- ☐ **Bleeding from your bladder or bowel** – usually mild and resolves, if not, further management may be required
- ☐ **Incontinence**

Rare
Less than 1%

- ☐ **Urinary retention** – not being able to pass urine or not being able to fully empty your bladder, both of which may result in needing a urinary catheter
- ☐ **Urinary incontinence including urine leaking**

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%

- ☐ **Infertility:**
  - – Radiotherapy will affect your fertility. Please let us know about your plans for having children and we can advise accordingly.

Common
10%–50%

- ☐ **Long-term urinary symptoms (the majority of which are mild) including:**
  - – Daytime/night-time frequency: passing urine more often than normal
  - – Urgency: a sudden urge to pass urine
- ☐ **Long-term bowel symptoms (the majority of which are mild) including:**
  - – Looser stools compared to your usual
  - – Urgency: a sudden urge to open your bowels
  - – Passing more mucous or wind compared to what is normal for you
- ☐ **Change in sexual experience including:**
  - – Changes in ejaculate such as reduced amount, altered consistency or blood in ejaculate
  - – Dry ejaculation or loss of orgasm
  - – Change to penile length/appearance
  - – Inability to achieve an erection (please note: ability may also be reduced with age, other health conditions or hormone medication you may be on as part of your treatment)

Less common
Less than 10%

- ☐ **Long-term urinary symptoms including:**
  - – Cystitis/pain when you urinate: due to bladder inflammation
  - – Incomplete emptying of your bladder or reduced bladder capacity
  - – Stricture: a narrowing in your water pipe which may require surgery
- ☐ **Long-term bowel symptoms including:**
  - – Frequency: opening your bowels more often than normal
  - – Rectal pain/discomfort due to rectal inflammation
- ☐ **Bleeding from your bladder or bowel** – usually mild and resolves, if not, further management may be required
- ☐ **Symptoms similar to irritable bowel syndrome** – intermittent tummy discomfort, altered bowel habit, passing more wind or mucous

Rare
Less than 1%

- ☐ **Urinary incontinence including urine leaking (1%)**
- ☐ **Pelvis/hip bone thinning and/or fractures**
- ☐ **Bowel/bladder damage which may require surgery including:**
  - – Perforation: a hole in your bladder or bowel
  - – Fistula: an abnormal connection between two parts of your body
  - – Bowel obstruction: a blockage of your bowel
  - – Severe bleeding from your bladder or bowel
- ☐ **An increased risk of a different cancer in the treatment area** – not related to your current cancer, which may occur many years after treatment

Specific to you if you are having radiotherapy to your pelvic lymph nodes:

- ☐ **Lymphoedema** – fluid build up in your legs and potentially your scrotum
- ☐ **Malabsorption** – problems with nutrient absorption which may require further medical management
- ☐ **Neuropathy** – damage to nerves which could lead to issues with pain, numbness, weakness in your legs. This is very rare.

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 understand that I should not father a child or donate sperm during the course of my treatment and I will discuss with my oncologist when it will be safe for me to father a child after radiotherapy.

☐ 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: