Radiotherapy consent form for skin 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**
- ☐ **Brachytherapy to the skin**

Site and side:
(Tick as appropriate)

Site

- ☐ **Left**
- ☐ **Right**
- ☐ **Central**

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 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 redness, irritation, soreness, itching, flaking, peeling, scaling and dryness in the treatment area**
- ☐ **The skin may scab over several times**
- ☐ **Skin breakdown in the treatment area** – for example oozing, weeping, scabbing and/or bleeding
- ☐ **Hair thinning or loss in radiotherapy area**

Common
10%–50%

- ☐ **Soreness** that may require non-prescription painkillers available from a pharmacy

Less common
Less than 10%

- ☐ **Infection in the treated area needing antibiotics**

Rare
Less than 1%

Specific risks to you from your treatment

Nose

- ☐ **Soreness, dryness, crusting or bleeding**

Lip and cheek

- ☐ **Redness, swelling or pain**

Eyelids

- ☐ **Redness or soreness around the eye**

Other

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%

- ☐ **Permanent skin texture changes in treatment area including** – thicker or thinner skin
- ☐ **Skin colour change in the treatment area** – usually lighter or darker
- ☐ **Permanent hair loss in and around treatment area** – if hair starts to regrow, it may be patchy

Common
10%–50%

- ☐ **Telangiectasia in the treatment area** – small visible blood vessels which look like spidery marks
- ☐ **Increased sensitivity of the treated skin to the sun and changes in temperature**

Less common
Less than 10%

- ☐ **Chronic non-healing ulcer** – this may require further treatment such as dressings or surgery

Rare
Less than 1%

- ☐ **Permanent damage to cartilage or bone in the treated area**
- ☐ **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

Nose

- ☐ **Runny nose or nose dryness**

Eyes

- ☐ **Dry eye or watery eye** which may require further treatment
- ☐ **Ectropion** – eyelid turns outwards/droops
- ☐ **Cataracts** – clouding in the lens of the eye, which may require surgery to correct

Skin grafts

- ☐ **Increased risk of graft failure** – the graft not healing

Other

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 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: