

# Radiotherapy consent form for head and neck cancer (upper sites)



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

<b>Radiotherapy treatment:</b>	<b>External beam radiotherapy</b>
<b>Site and side:</b> (Tick as appropriate)	<input type="checkbox"/> Nasopharynx <input type="checkbox"/> Nasal cavity <input type="checkbox"/> Sinuses <input type="checkbox"/> Salivary glands <input type="checkbox"/> Ear <input type="checkbox"/> Other _____
<b>Aim of treatment:</b> (Tick as appropriate)	<input type="checkbox"/> <b>Curative</b> – to give you the best chance of being cured <input type="checkbox"/> <b>Adjuvant</b> – treatment given after surgery to reduce the risk of cancer coming back <input type="checkbox"/> <b>Disease control/palliative</b> – to help you live longer but not to cure the cancer <input type="checkbox"/> <b>Disease control/palliative</b> – to improve your symptoms but not to cure the cancer
<b>Concurrent systemic anti-cancer therapy:</b> (Tick as appropriate)	<input type="checkbox"/> Yes with _____ <input type="checkbox"/> 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.

<p><b>Expected</b> 50%–100%</p>	<ul style="list-style-type: none"><li><input type="checkbox"/> Tiredness</li><li><input type="checkbox"/> Skin soreness, redness and itching in the treatment area</li><li><input type="checkbox"/> Red or watery eyes</li><li><input type="checkbox"/> Irritation in the lining of the nose or blocked nose</li><li><input type="checkbox"/> Mouth ulcers</li><li><input type="checkbox"/> Pain in the mouth and/or throat which can cause problems with swallowing</li><li><input type="checkbox"/> Loss or change of taste</li><li><input type="checkbox"/> Hair loss in treatment area</li><li><input type="checkbox"/> Anxiety, low mood, feeling fed-up or poor sleep</li></ul>
<p><b>Common</b> 10%–50%</p>	<ul style="list-style-type: none"><li><input type="checkbox"/> Changes in or loss of smell</li><li><input type="checkbox"/> Temporary hearing loss and/or earache</li><li><input type="checkbox"/> Dry mouth</li><li><input type="checkbox"/> Mouth infections including oral thrush</li><li><input type="checkbox"/> Voice changes</li><li><input type="checkbox"/> Thickened and tenacious secretions</li><li><input type="checkbox"/> Nausea – feeling sick</li><li><input type="checkbox"/> Loss of appetite</li><li><input type="checkbox"/> Weight loss</li><li><input type="checkbox"/> Difficulty swallowing which may require temporary placement of a feeding tube at the start of treatment or during treatment to support nutrition and hydration</li><li><input type="checkbox"/> Risk of hospital admission</li></ul>
<p><b>Less common</b> Less than 10%</p>	<ul style="list-style-type: none"><li><input type="checkbox"/> Chest infection which may be due to food and/or secretions going down the windpipe</li><li><input type="checkbox"/> Dehydration as a result of reduced oral intake</li><li><input type="checkbox"/> Vomiting</li><li><input type="checkbox"/> Lhermitte's sign – temporary changes to the spinal cord presenting as a sudden electric shock like sensation on bending the neck, may occur three to six months after treatment</li></ul>
<p><b>Rare</b> Less than 1%</p>	<ul style="list-style-type: none"><li><input type="checkbox"/> Risk to life</li></ul>
<p><b>Specific risks to you from your treatment</b></p>	
<p>I confirm that I have had the above side-effects explained.</p>	
	<p>Patient initials </p>

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>Skin colour change in the treatment area</b> – usually lighter or darker <input type="checkbox"/> <b>Lymphoedema</b> – skin, chin and soft-tissue swelling
<b>Common</b> 10%–50% 	<input type="checkbox"/> <b>Permanent skin texture changes in treatment area</b> – thicker or thinner skin <input type="checkbox"/> <b>Telangiectasia in the treatment area</b> – small visible blood vessels which look like spidery marks <input type="checkbox"/> <b>Hair loss in the treatment area or patchy re-growth</b> <input type="checkbox"/> <b>Permanent dryness of nose</b> <input type="checkbox"/> <b>Nasal crusting</b> <input type="checkbox"/> <b>Dry mouth</b> <input type="checkbox"/> <b>Altered taste or loss of taste</b> – with possibility of some recovery over 18 months <input type="checkbox"/> <b>Hypothyroidism</b> – under-active thyroid gland, which may require you to take medication <input type="checkbox"/> <b>Cataract</b> – clouding in the lens of the eye, which may require surgery to correct
<b>Less common</b> Less than 10% 	<input type="checkbox"/> <b>Dry eye</b> <input type="checkbox"/> <b>Visual changes and damage to the eye</b> <input type="checkbox"/> <b>Nasal regurgitation/reflux</b> <input type="checkbox"/> <b>Loss of smell</b> <input type="checkbox"/> <b>Hearing loss or hearing changes</b> <input type="checkbox"/> <b>Dental problems</b> <input type="checkbox"/> <b>Trismus</b> – jaw stiffness <input type="checkbox"/> <b>Voice changes</b> <input type="checkbox"/> <b>Swallowing problems</b> – with risk of long-term/permanent feeding tube requirement <input type="checkbox"/> <b>Increased risk of stroke</b> <input type="checkbox"/> <b>Pituitary dysfunction</b> – your pituitary gland not producing enough hormones, this may require you to take medication to replace the hormones <input type="checkbox"/> <b>Osteoradionecrosis of the jaw</b> – damage to the jawbone
<b>Rare</b> Less than 1% 	<input type="checkbox"/> <b>Permanent changes to brainstem, spinal cord and nerves to the face, arm or hand</b> <input type="checkbox"/> <b>Radionecrosis of the brain</b> – damage to a small area of the brain which is not repairable <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>
<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 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 understand that if I were to continue to smoke it could have a significant impact on the side-effects I experience and the efficacy of my treatment.

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: