CONSENT TO RADIATION THERAPY

TREATMENT FOR ________________________

DOCTOR(S):_____________________________

I, by signing this form, am giving consent and asking that the radiation treatment course (listed above) be performed by the doctors, nurses, and other technical people in the Department of Radiation Oncology. I know the doctor(s) named above may have other doctors assist and/or take their place during the treatment(s).

I talked to a doctor before I signed this form. This doctor explained to me what my condition appears to be and the kinds of treatment(s) given for this condition. We also discussed what will be done in this treatment, what the available alternatives are, and why it may help. I understand that I have the right to refuse this radiation. I have informed my Radiation Oncology doctor if I have received any prior radiation.

I understand that my condition may be treated with external beam radiation therapy and/or surgery and/or chemotherapy and/or brachytherapy (internal radiation) and/or other cancer therapies.

I understand that an identification photograph of my face will be taken as well as photographs of the treatment fields to aid with setting up and positioning on a daily basis. It has also been explained to me that small permanent tattoo marks may be made on my skin to mark the treatment area and assist with treatment set up. This will require that my skin be punctured by a sterile needle and a drop of tattoo dye placed in the puncture to leave a permanent mark. I may receive contrast during the setup and have informed my Radiation Oncology doctor if I am allergic to contrast material or have kidney problems.

I understand that the radiation treatment(s) may cause some side effects and complications. Some of the more general side effects include a skin reaction (similar to a sunburn) and/or hair loss in the area being treated, lowered blood counts and feeling tired. Other side effects and possible complications related to the specific area being treated include, but are not limited to, the following:

Early effects - 

Late effects - 

The doctor has explained all of this to my satisfaction. I know I can ask more questions if I wish. I understand that if I am a woman of childbearing potential that I must use an adequate form of contraception prior to and during the course of radiation therapy. If I have any questions with regard to possible pregnancy, I will discuss this with my Radiation Oncology physician prior to my radiation planning session. I understand that if I am pregnant or become pregnant, I may not be able to undergo radiation therapy and must notify my Radiation Oncology physician immediately.

I know medical science is not perfect, and many things are not predictable. Nobody has given me a promise or guarantee of what the results of the treatment(s) will be.

I have read (or had read to me) the above Consent to Radiation Therapy. I know what it means and I consent to the radiation treatment(s).

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I have discussed the reasonably expected risks and benefits of the radiation treatment(s) and have given the patient or patient's representative sufficient information to permit informed consent.

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