

Radiotherapy consent form for head and neck cancer (lower sites)

This form should only be used if the patient is over 16 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 therapeutic radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy

Radiotherapy type:	External beam radiotherapy	
Site and side: (Tick as appropriate)	<input type="checkbox"/> Oral cavity <input type="checkbox"/> Oropharynx <input type="checkbox"/> Larynx <input type="checkbox"/> Hypopharynx <input type="checkbox"/> Other _____	Radiotherapy to the neck <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral (both sides)
Aim of treatment: (Tick as appropriate)	<input type="checkbox"/> Curative – to give you the best chance of being cured <input type="checkbox"/> Adjuvant – treatment given after surgery to reduce the risk of cancer coming back <input type="checkbox"/> Disease control/palliative – to improve your symptoms and/or help you live longer but not to cure your cancer	
Concurrent systemic anti-cancer therapy: (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 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>Expected 50%–100%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Tiredness<input type="checkbox"/> Skin soreness, itching, blistering and colour changes in treatment area – redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones<input type="checkbox"/> Thickened and tenacious secretions<input type="checkbox"/> Dry mouth<input type="checkbox"/> Oral ulcers<input type="checkbox"/> Pain in the mouth and/or throat which can cause problems with swallowing<input type="checkbox"/> Loss or change of taste<input type="checkbox"/> Voice changes<input type="checkbox"/> Cough<input type="checkbox"/> Loss of appetite<input type="checkbox"/> Hair loss in treatment area<input type="checkbox"/> Anxiety, low mood, feeling fed-up or poor sleep
<p>Common 10%–50%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Blocked ear and/or earache<input type="checkbox"/> Mouth infections including oral thrush<input type="checkbox"/> Nausea – feeling sick<input type="checkbox"/> Vomiting<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
<p>Less common Less than 10%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Chest infection which may be due to food and/or secretions going down the windpipe<input type="checkbox"/> Dehydration as a result of reduced oral intake<input type="checkbox"/> Swelling of voice box – laryngeal oedema<input type="checkbox"/> Risk of hospital admission<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
<p>Rare Less than 1%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Risk to life
<p>Specific risks to you from your treatment</p>	
<p>I confirm that I have had the above side-effects explained.</p>	

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% 	<input type="checkbox"/> Skin colour change in the treatment area – usually lighter or darker for any skin tone <input type="checkbox"/> Lymphoedema – skin, chin and soft-tissue swelling <input type="checkbox"/> Dry mouth <input type="checkbox"/> Altered taste or loss of taste – with possibility of some recovery over 18 months <input type="checkbox"/> Hair loss in the treatment area or patchy re-growth
Common 10%–50% 	<input type="checkbox"/> Permanent skin texture changes in treatment area – thicker or thinner skin <input type="checkbox"/> Telangiectasia in the treatment area – small visible blood vessels which look like spidery marks <input type="checkbox"/> Dental problems <input type="checkbox"/> Trismus – jaw stiffness <input type="checkbox"/> Voice changes <input type="checkbox"/> Hypothyroidism – under-active thyroid gland, which may require you to take medication
Less common Less than 10% 	<input type="checkbox"/> Hearing loss or changes <input type="checkbox"/> Osteoradionecrosis of the jaw – damage to the jawbone <input type="checkbox"/> Swallowing problems with risk of long-term/permanent feeding tube requirement <input type="checkbox"/> Laryngeal chondronecrosis – irreversible damage to the voice box <input type="checkbox"/> Increased risk of stroke
Rare Less than 1% 	<input type="checkbox"/> Permanent changes to brainstem, spinal cord and nerves to the face, arm or hand <input type="checkbox"/> A different cancer in the treatment area <input type="checkbox"/> 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

- I have had the aims and possible side effects of treatment explained to me and the opportunity to discuss alternative treatment and I agree to the course of treatment described on this form.
- I understand that a guarantee cannot be given that a particular person will perform the radiotherapy. The person will, however, have appropriate expertise.
- 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 agree that information collected during my treatment, including images and my health records may be used for education, audit and research. All information will be anonymised. I am aware I can withdraw consent at anytime.

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. Testosterone and other hormone treatments are not contraception.

- 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:

Patient name:

Date:

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:

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.

Patient initials

Date: