



RADIATION THERAPY OF ABDOMEN CONSENT

Name _____ Date of Birth _____

This information is given to you so that you can make an informed decision about receiving radiation therapy for cancer in the: Abdomen Stomach

Reason and Purpose of the Procedure:

- Radiation therapy is used to destroy cancer cells in this specific area.
- You will have this therapy Monday through Friday for _____ weeks.
Tiny permanent marks (tattoos) are made on your skin to show the area to be treated.
- Digital photos will be taken for identification purposes.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Delay or prevent the spread of cancer at that site.
- Improve symptoms.
- Increase chance of cure.

Risk of this Procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

The side effects of radiation therapy depend on where the radiation is aimed. It may not be the same for each person. Common side effects include:

- Skin changes similar to a sunburn at the site where the radiation beam was aimed.
- Fatigue and tiredness
- Nausea and vomiting.
- Low blood cell counts.
- Diarrhea
- Heartburn
- Bowel damage.
- Injury to the spinal cord.

Risks specific to you:

Side effects are often worse if radiation and chemotherapy are given together. These side effects usually go away soon after treatment.

Alternative Treatments:

- Observation
- Chemotherapy
- Surgery

If you choose not to have this treatment:

- Your cancer may get worse.

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: _____.

Patient

Signature _____

Relationship

- Patient/parent of minor Closest Relative/Relationship Guardian/POA
Healthcare

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter (if applicable)

Date

Time

For provider use only:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options and possibility of complications and side effects of the intended intervention. I have answered questions and patient has agreed to procedure.

Provider Signature _____ Date _____ Time _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure : _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

or

____ Patient elects not to proceed _____ (patient signature)

Validated/Witness: _____ Date: _____ Time: _____