BRONSON
Battle Creek

Cancer Care Center

Affix Patient Label

RADIATION THERAPY OF BRAIN CONSENT

Name_____ Date of Birth_____

This information is given to you so that you can make an informed decision about having radiation therapy for cancer in the brain.

Reason and Purpose of the Procedure:

- Radiation therapy helps destroy cancer cells.
- You will have therapy Monday through Friday for__weeks.
- Marks are placed on the mask to show the area to be treated.
- Digital photos will be taken for identification purposes and to make sure the setup is correct.

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.
- Improve symptoms.

Risks 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.

- Tiredness
- Irritation of the ears.
- Temporary or permanent hair loss.
- Headaches
- Possible decrease in hearing.
- Irritation of the eyes, possible cataract (clouding of the lens).
- Temporary loss of short term memory.
- Upset stomach

Risks specific to you:

_____
_____
_____
_____

Alternative Treatments:

- Observation
- Surgery
- Chemotherapy

If you choose not to have this treatment:

- Cancer may get worse or recur.

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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_____