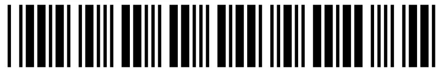

Cancer Care Center

Affix Patient Label

RADIATION THERAPY OF BREAST/CHEST 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: ☐ **Breast** ☐ **Chest wall**

Reason and Purpose of the Procedure:

- Radiation Therapy uses high energy rays to destroy cancer cells for local control of your condition.
- This therapy is given weekdays for____________weeks.
- Tiny permanent marks (tattoos) will be given to localize the area to be treated.
- Digital photos will be taken for identification (ID) purposes and to confirm correct setup and tattoos are used.

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 prevention of the spread of cancer at that site.
- Improve symptoms
- Increase the chance of a cure.

Risks of this Procedure:

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

- Skin changes similar to sunburn at the site where the radiation beam was aimed.
- Fatigue or tiredness
- Swelling and heaviness in the breast.
- Low blood counts.
- Scarring of underlying tissue including lung.
- Lymphedema (swelling of the arm).
- Small risk of secondary cancer.
- 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.

Risks specific to you:

____

____

____

Often these effects go away shortly after treatment.

Alternative Treatments:

- Chemotherapy
- Surgery
- Hormone Therapy

If you choose not to have this treatment:

- The cancer may spread or come back.

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/POAHealthcare

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: _________