BRONSON
Battle Creek

Cancer Care Center

Affix Patient Label

RADIATION THERAPY OF ESOPHAGUS 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:

Esophagus: _____

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 locate the area to be treated.
- Digital photos will be taken for identification purposes and to make sure the correct setup is used and correct 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 such as trouble swallowing, bleeding or pain.
- Increase chance of a cure.
- Shrink the tumor so it is easier to remove.

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 a sunburn at the site where the radiation beam was aimed.
- Fatigue or tiredness
- Nausea and/or vomiting.
- Low blood counts.
- Diarrhea
- Heartburn
- Bowel damage
- 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:

_____

_____

_____

_____

Side effects tend to be worse if radiation and chemotherapy are given together. Often these side effects go away shortly after treatment.

Alternative Treatments:

- Observation
- Chemotherapy
- Surgery

BRONSON Battle Creek	**Cancer Care Center**	Affix Patient Label

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: _____