BRONSON
Battle Creek

**Cancer Care Center**

Affix Patient Label

## RADIATION THERAPY OF GYNECOMASTIA CONSENT

Name:_____ Date of Birth: _____

This information is given to you so that you can make an informed decision about receiving radiation therapy

**For: Gynecomastia (enlarged breasts in men)**

**Reason and Purpose of the Procedure:**

- Gynecomastia is enlargement of the male breast. It is often painful. It is not cancer.
- Men who are treated with hormone therapy may develop some breast enlargement or breast tenderness.
- Low dose radiation can prevent or lower the risk of this developing.
- Marks will be made at the site of treatment.
- Digital photos will be taken for identification (ID) purposes and to confirm correct setup.

**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.

- Prevent or lower the risk of breast tenderness.
- Prevent or lower the risk of breast enlargement.

**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.
- Skin irritation.
- 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:**

_____

_____

_____

**Alternative Treatments:**

- Observation

**If you choose not to have this treatment**

- Your symptoms may become worse.

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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: _____