BRONSON
Battle Creek

Cancer Care Center

Affix Patient Label

RADITION THERAPY OF HEAD & NECK 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: Head and/or Neck region.

Reason and Purpose of the Procedure:

- Radiation Therapy to the head/neck which may include the upper chest region uses high energy rays to destroy cancer cells for local control of your condition.
- This therapy is given weekdays for_____weeks.
- Marks will be placed on the mask to localize the area to be treated.
- Digital photos will be taken for identification purposes and to assure 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.

- Delay or prevention of the spread of cancer.
- Improve symptoms
- Increase chance for a cure.

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.

- Irritation or damage of tissue at the site of treatment.
- Sore mouth, tongue and/or throat. This is temporary.
- Dental problems
- Taste changes
- Loss of appetite
- Weight loss
- Trouble swallowing
- Hoarseness
- Fatigue (tiredness)
- Low blood counts
- Skin changes similar to sunburn at the site where the radiation beam was aimed.
- Some hair loss
- Depressed thyroid function

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

Risks specific to you:

_____

_____

_____

Alternative Treatments:

- Surgery
- Chemotherapy
- Observation

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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: _____