BRONSON
Battle Creek

Cancer Care Center

Affix Patient Label

RADIATION THERAPY OF LUNG 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 lung:

Reason and Purpose of the Procedure:

- Radiation therapy is used to help destroy cancer cells.
- You will have therapy Monday through Friday for _____ weeks.
- Tiny permanent marks (tattoos) are made on your skin to show the area to be treated.
- Digital photos will be taken for identification purposes.

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 the spread of cancer.
- Improve symptoms.
- Improve chance of 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.

- Radiation can irritate or damage tissue.
- Fatigue (tiredness)
- Low blood counts
- Skin changes similar to sunburn at the site where the radiation beam was aimed
- Temporary sore throat or trouble swallowing
- Scarring of underlying tissue including the lung and/or heart.
- Some shortness of breath
- Injury of the spinal cord
- Chest pain

Risks specific to you:

_____

_____

_____

Alternative Treatments:

- Surgery
- Chemotherapy
- No treatment at all

If you choose not to have this treatment:

- Your cancer may get worse.
- Your symptoms may get 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: _____