

**RADIATION THERAPY METASTATIC 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 that has spread to _____.

Reason and Purpose of the Procedure:

- Radiation therapy destroys cancer cells.
- This therapy is given every day, 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 or stop the spread of cancer.
- Improve symptoms and quality of life.
- Reduce pain.

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.

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.

RADIATION THERAPY METASTATIC CONSENT

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: _____