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

RADIATION THERAPY OF PROSTATE 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: **Prostate**_____

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 localize the area to be treated.
- Digital photos will be taken for identification purposes (ID).

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

Risk 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 changes similar to a sunburn at the site where the radiation beam was aimed.
- Fatigue **or** tiredness
- Nausea
- Rectal irritation. This can cause diarrhea, painful bowel movements, or blood in the stool.
- Bowel incontinence (stool leakage).
- Bladder irritation. This can cause problems like feeling like you have to go often (called frequency), burning while urinating, or blood in the urine.
- Sexual problems (impotence)
- Low blood counts
- Bowel and/or bladder damage
- Bowel obstruction

Risk 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:

- No treatment at all
- Chemotherapy
- Surgery

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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: _____