

**STEREOTACTIC RADIATION THERAPY CONSENT**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This information is given to you so that you can make an informed decision about having **Stereotactic Body Radiation Therapy (SBRT) to the chest for lung cancer.**

**Reason and Purpose of the Procedure:**

- SBRT is used to treat tumors in the lung.
- This type of radiation therapy helps spare normal tissue while controlling tumor growth.
- You will be treated once a day from one to five days. Treatment will be complete in one to two weeks.
- Before starting SBRT a 3D image of the tumor is made.
- The radiation dose is matched with the exact size of the tumor.
- The radiation beams target the tumor and do not harm healthy lung tissue.

**With Sterotactic Body Radiation you will receive:**

- Higher radiation doses to tumors. This is not possible with other radiation therapies.
- Less damage to healthy lung tissue.
- Fewer number of treatments than standard radiation therapy.

**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 cancer cells not spreading.

**Risk of 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.

**Very Likely and Serious:**

- The collapse of part of the treated lung.
- This collapse generally affects a small portion of the lung. The collapse can be permanent.
- If a part of your lung does collapse, you will have shortness of breath at rest or during exercise. This can be permanent.
- You may need to receive oxygen.
- You may have chest wall pain.
- You may need oxygen therapy permanently.
- A collapse of a portion of your lung may be life threatening.

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**Very Likely**

- Tiredness. This is temporary.
- The skin in the treatment area may become reddened and /or dry
- Chest hair may fall out. It may not grow back.

**Less Likely:**

- Cough
- Difficulty breathing
- Irritation of the esophagus. This may cause heartburn or pain on swallowing.
- Fever
- Chest wall discomfort or pain.
- Rib fracture. This may cause pain.

**Less Likely, but Serious:**

- Irritation of the lining around the heart. This can cause chest pain, shortness of breath, and irregular or rapid heartbeat. Although rare, you may need surgery.
- Irritation and/or damage to the muscle of the heart. This can cause a heart attack, heart failure, and/or death. This is rare.
- Irritation and/or damage to the spinal cord (the major nerve within the spine). This can lead to weakness, tingling or numbness of the lower body and legs. Very rarely, this can lead to inability to move or control the lower half of the body.
- Damage or scarring of nerves in the chest. This may cause a hoarse voice or a tingling “pins and needles” feeling. This may also cause pain in the rib or chest area.
- Damage or scarring of nerves at the top of the lungs. This may result in a tingling “pins and needles” feeling or pain and weakness of the arm and hand.
- Narrowing of the esophagus (tube to the stomach). This can cause difficulty in swallowing.
- Thinning of the esophagus wall. This can cause a hole in the esophagus. This is rare.
- Irritation of the large blood vessels surrounding the heart. This can cause bleeding (coughing up blood) and/or death. This is rare.

**Reproductive Risks:**

- You should not become pregnant or father a baby while under treatment. Radiation therapy can affect an unborn baby.
- If you are a female and have not had a tubal ligation or hysterectomy, you must have a pregnancy test before treatment.
- Women should not breastfeed a baby during treatment.
- For patients who are sexually active, some type of birth control must be used during treatment.

**Alternative Treatments:**

- Getting standard radiation treatment
- Chemotherapy
- Getting no treatment
- Surgery

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

- Your symptoms or cancer may get worse.

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*ADULT Use Only*

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: \_\_\_\_\_

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