BRONSON
Battle Creek

Cancer Care Center

Affix Patient Label

RADIATION THERAPY OF SKIN CONSENT

Name: _____Date of Birth: _____

This information is given to you so that you can make an informed decision about having radiation therapy for cancer in the skin. _____

Reason and Purpose of the Procedure:

- Radiation therapy is used to destroy cancer cells in a specific area. You will have therapy Monday through Friday for _____ weeks.
- Tiny permanent marks (tattoos) are made 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 that you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Delay or prevent of the spread of cancer at that site.
- Improve symptoms.
- Increase 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.

The side effects of radiation therapy depend on where the radiation is aimed. They may not be the same for each person. Common side effects are:

- Skin changes similar to a sunburn at the site where the radiation beam was aimed.
- Fatigue (tiredness)
- Changes in skin color. This is usually temporary.
- Dryness.
- Blistering or peeling of skin.
- Increase fragility of treated skin.
- Irritation of tissue under the skin.

Risks specific to you:

_____

_____

_____

Often side effects go away shortly after treatment.

Alternative Treatments:

- Observation
- Surgery

If you choose not to have this treatment:

- Your cancer 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: _____