BRONSON
Battle Creek

Cancer Care Center

Affix Patient Label

HIGH DOSE RATE GYNECOLOGICAL BRACHYTHERAPY CONSENT

Name: _____Date of Birth: _____

This information is given to you so that you can make an informed decision about receiving High Dose Rate Brachytherapy. This is radiation therapy for cancer in the gynecological region.

Reason and Purpose of the Procedure:

- Radiation therapy uses high energy rays to destroy cancer cells in this specific area. You will have Monday through Friday for _____ treatments.
- 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 prevention of the spread of cancer at that site.
- Improve symptoms
- Increase chance of 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.

- Blood clots in veins which could travel to the lungs
- Diarrhea
- Increased frequency of urination
- Vaginal changes including shrinkage. This might affect satisfactory sexual relations.
- Sterility. You will not be able to have children.

Later complications (usually after 6 months or more) are extremely rare. This can include:

- Recurrent diarrhea
- Swelling and/or ulceration of the bowel. This could result in bleeding or a blockage. You may need surgery including an ostomy.
- Scar tissue formation in the bladder or urethra.
- Blood in urine.

Risks 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:

- Observation
- Chemotherapy
- 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: _____