BRONSON
Battle Creek

Affix Patient Label

# THYROID CANCER – RADIOACTIVE IODINE-131 CONSENT

Name: _____ Date of Birth: _____

This information is to help you make an informed decision about receiving Radioactive Iodine-131 treatment for thyroid cancer.

**Reason and Purpose of the Procedure of Radioactive Iodine-131:**

- This treatment is done after you have surgery to remove your thyroid because of cancer. It is done to treat the specific area to prevent cancer from recurring. You will take a pill by mouth while you are at the Cancer Care Center.

**Benefits of this Procedure:** You may 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.

- Prevent cancer from coming back
- Pain control.

**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.

- Nausea
- Vomiting
- Diarrhea
- Dry mouth
- Headache

**Things to know about this procedure:**

- Go home right away after treatment.
- Do not stay at a hotel after having the treatment.
- Keep at least 3 feet away from others for 5 days.
- Avoid pregnant women and children for 5 days.
- Sleep alone for 5 days.
- DO NOT kiss or have sexual intercourse for 5 days.
- Be the **only** person to use a bathroom for 5 days. Flush toilet 2-3 times a day for 5 days.
- **DO NOT** use mass transportation (bus, train, and airplane). Do not travel in a car with others for longer than one hour for 5 days.
- Drink plenty of fluids.
- Wash hands before preparing food and after using the bathroom for 5 days.
- **DO NOT** share food or items that touch your mouth for 5 days.
- Use disposable eating utensils and plates for 5 days.
- Use separate bath towels and linens for 5 days. Wash separately with underclothes for 5 days.
- **DO NOT** have routine blood, urine, or medical tests done for 5 days.
- Tell all medical providers you have received a radioactive iodine therapy.
- **DO NOT** become pregnant for one year after treatment.
- **MUST STOP** breast-feeding. Failure to do so could harm your child's thyroid.

**Risks specific to you:**

_____

_____

_____

**Alternative Treatments:**

- Other treatment plans.
- No treatment at all.
- Supportive follow up with symptom management.

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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: _____