The Royal College of Radiologists

Radiotherapy consent form for benign skin and soft tissue conditions

This form should only be used if the patient is over 16 years old and has capacity to give consent. If the patient does not legally have capacity please use an appropriate alternative consent form from your hospital.

Patient details

Patient name:

Date of birth:

Patient unique identifier:

Name of hospital:

Responsible consultant oncologist or consultant therapeutic radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy

Radiotherapy type:	☐ External beam radiotherapy ☐ Brachytherapy to the skin
Site and side: (Tick as appropriate)	**Site** ☐ Left ☐ Right ☐ Central
Aim of treatment: (Complete as appropriate)	

You may have questions before starting, during or after your radiotherapy.

Contact details are provided here for any further queries, concerns or if you would like to discuss your treatment further.

Patient name:

Patient unique identifier:

Possible early or short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected
50%–100%

- ☐ **Tiredness**
- ☐ **Skin irritation, itching, flaking, peeling, scaling, dryness, colour changes in the treatment area** – redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones
- ☐ **The skin may scab over several times**
- ☐ **Skin breakdown in the treatment area** – for example oozing, weeping, scabbing and/or bleeding
- ☐ **Hair thinning or loss in radiotherapy area**

Common
10%–50%

- ☐ **Soreness** that may require non-prescription painkillers available from a pharmacy
- ☐ **Delay in wound healing**

Less common
Less than 10%

- ☐ **Infection in the treated area needing antibiotics**

Rare
Less than 1%

Specific risks to you from your treatment

Nose

- ☐ **Soreness, dryness, crusting or bleeding**

Lip and cheek

- ☐ **Swelling or pain**

Eyelids

- ☐ **Soreness**
- ☐ **Impact on mobility and function**

Other

☐ **I confirm** that I have had the above side-effects explained.

Patient initials

Patient name: _____ **Patient unique identifier:** _____

Possible late or long-term side-effects

May happen many months or years after radiotherapy and may be permanent. Frequencies are approximate.

Expected
50%–100%

- ☐ **Permanent skin texture changes in treatment area** – including thicker or thinner skin
- ☐ **Skin colour change in the treatment area** – usually lighter or darker for any skin tone
- ☐ **Permanent hair loss in and around treatment area** – if hair starts to regrow, it may be patchy or a change in texture

Common
10%–50%

- ☐ **Telangiectasia in the treatment area** – small visible blood vessels which look like spidery marks
- ☐ **Altered sensitivity of the treated skin to the sun and changes in temperature**
- ☐ **Anhidrosis in the treatment area** – loss of function of sweat glands causing them to reduce or stop sweat production

Less common
Less than 10%

- ☐ **Chronic non-healing ulcer** – this may require further treatment such as dressings or surgery

Rare
Less than 1%

- ☐ **Permanent damage to cartilage or bone in the treated area**
- ☐ **A cancer in the treatment area** – which may occur many years after treatment

Specific risks to you from your treatment

Nose

- ☐ **Runny nose or nose dryness**

Eyes

- ☐ **Dry eye or watery eye** which may require further treatment
- ☐ **Ectropion** – eyelid turns outwards/droops
- ☐ **Cataracts** – clouding in the lens of the eye, which may require surgery to correct

Mouth

- ☐ **Xerostomia** – a dry mouth caused by a reduction in the production of saliva by the salivary glands

Other

I confirm that I have had the above side-effects explained.

Patient initials _____

Patient name:

Patient unique identifier:

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure)

– I have discussed what the treatment is likely to involve, the intended aims and side-effects of this treatment.
– I have also discussed the benefits and risks of any available alternative treatments including no treatment.
– I have discussed any particular concerns of this patient.

Patient information leaflet provided: ☐ Yes / ☐ No – Details:

Copy of consent form accepted by patient: ☐ Yes / ☐ No

Signature:

Date:

Name:

Job title:

Statement of patient

- I have had the aims and possible side effects of treatment explained to me and the opportunity to discuss alternative treatment and I agree to the course of treatment described on this form.
- I understand that a guarantee cannot be given that a particular person will perform the radiotherapy. The person will, however, have appropriate expertise.
- I have been told about additional procedures which are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks and photographs to help with treatment planning and identification.
- I agree that information collected during my treatment, including images and my health records may be used for education, audit and research. All information will be anonymised. I am aware I can withdraw consent at anytime.

Tick if relevant

☐ I confirm that there is no risk that I could be pregnant.

☐ I understand that I should not become pregnant during treatment.

Note: if there is any possibility of you being pregnant you must tell your hospital doctor/health professional before your treatment as this can cause significant harm to an unborn fetus. Testosterone and other hormone treatments are not contraception.

☐ I understand that I should not concieve a child or donate sperm or eggs during the course of my treatment and I will discuss with my oncologist when it will be safe for me to concieve a child after radiotherapy.

☐ I understand that if I were to continue to smoke it could have a significant impact on the side-effects I experience and the efficacy of my treatment.

☐ I do not have a pacemaker and/or implantable cardioverter defibrillator (ICD).

or

☐ I have a pacemaker and/or implantable cardioverter defibrillator (ICD) and I have had the risks associated with this explained to me.

Signature:

Patient name:

Date:

Statement of:

☐ **interpreter**
☐ **witness** (where appropriate)

☐ I have interpreted the information contained in this form to the patient to the best of my ability and in a way in which I believe they can understand.

or

☐ I confirm that the patient is unable to sign but has indicated their consent.

Signature:

Name:

Date:

Patient confirmation of consent

(To be signed prior to the start of radiotherapy)

I confirm that I have no further questions and wish to go ahead with treatment.

Patient initials

Date:

