The Royal College of Radiologists

Radiotherapy consent form: Stereotactic Radiosurgery (SRS) or Stereotactic Radiotherapy (SRT) for brain tumours

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

Stereotactic radiosurgery (SRS) or Stereotactic radiotherapy (SRT) is high dose precision radiotherapy for treatment for brain tumours

Indication:	
Site:	
Aim of treatment: (Tick as appropriate)	☐ **Radical** – treatment given with an aim of long term control ☐ **Adjuvant** – treatment given after surgery to reduce the risk of the tumour coming back ☐ **Disease / symptom control** – treatment given to delay progression of the tumour and / or delay worsening of symptoms
Concurrent systemic anti-cancer therapy (SACT): (Tick as appropriate)	☐ **Currently not on SACT treatment** ☐ **SACT treatment to continue without interruption** ☐ **Interruption of SACT treatment**

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.

Driving advice:	☐ If you drive, and you have a new diagnosis of a brain tumour or have had a seizure or receive treatment to the brain, you are required to notify the Driver and Vehicle Licensing Agency (DVLA). **You should not drive until formally advised you can do so.**

Patient name:

Patient unique identifier:

Possible short-term side-effects

Short term side effects start during radiotherapy or shortly after completion of radiotherapy. They usually resolve within two to six months of completion of treatment.

The possibility and severity of symptoms from radiotherapy to the brain can vary, depending on the location of the tumour and the area being treated. Symptoms may include:

	Expected 50%–100%	**Common** 10%–50%	**Less common** Less than 10%	**Rare** Less than 1%
General radiotherapy risks				
Tiredness	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Loss of appetite	☐	☐	☐	☐
Nausea or vomiting	☐	☐	☐	☐
Small area of hair loss near the treatment area which is usually temporary	☐	☐	☐	☐
Skin changes including soreness, itching or colour changes	☐	☐	☐	☐
Worsening of tumour-related symptoms caused by swelling (oedema) of the brain and may require a course of steroids for treatment	☐	☐	☐	☐
Worsening or onset of seizures (epilepsy), which may require long term treatment with anti-seizure medication	☐	☐	☐	☐
Changes to memory, concentration or slowing of thought	☐	☐	☐	☐
Bleeding in or around the tumour after radiotherapy	☐	☐	☐	☐
Specific risks which relate to the site of treatment				
Changes in vision	☐	☐	☐	☐
Dryness or soreness of the eye	☐	☐	☐	☐
Changes in hearing which may include: hearing loss, tinnitus (ringing or unusual sounds in the ear) or a feeling of fullness in the ear	☐	☐	☐	☐
Changes to balance, dizziness or co-ordination	☐	☐	☐	☐
Build-up of fluid within the brain (hydrocephalus). This may require an operation to insert a shunt and, rarely, lead to death	☐	☐	☐	☐
Other specific risks to you from your treatment				

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

Long term side effects may start months or years after treatment or be the result of short-term side effects that fail to resolve. They may be permanent. Symptoms may include:

	Expected 50%–100%	**Common** 10%–50%	**Less common** Less than 10%	**Rare** Less than 1%
General radiotherapy risks				
Radionecrosis – a small area of irreversible change in the brain, which may be symptomatic or identified on scans. This may require treatment with steroids or rarely requires surgery	☐	☐	☐	☐
Worsening or onset of seizures (epilepsy), which may require long term treatment with anti-seizure medication	☐	☐	☐	☐
Permanent hair thinning or loss	☐	☐	☐	☐
Changes to memory, concentration or slowing of thought	☐	☐	☐	☐
Stroke (cerebrovascular accident, CVA) or **mini-stroke** (transient ischaemic attack, TIA)	☐	☐	☐	☐
A benign tumour or different cancer in the treatment area	☐	☐	☐	☐
Specific risks which relate to the site of treatment				
Changes to pituitary hormone function resulting in low hormone levels (hypopituitarism). This may cause symptoms and require medical treatment such as long-term hormone replacement	☐	☐	☐	☐
Dryness of the eye	☐	☐	☐	☐
Change or loss of vision	☐	☐	☐	☐
Changes in hearing which may include hearing loss or tinnitus (ringing or unusual sounds in the ear)	☐	☐	☐	☐
Changes to balance, dizziness or co-ordination	☐	☐	☐	☐
Changes to taste or smell	☐	☐	☐	☐
Build-up of fluid within the brain (hydrocephalus) this may require an operation to insert a shunt and, rarely, lead to death	☐	☐	☐	☐
Other specific risks to you from your treatment				

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 conceive 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 conceive 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:

