The Royal College of Radiologists

Radiotherapy consent form: Stereotactic Radiosurgery (SRS) or Stereotactic radiotherapy (SRT) for vestibular schwannoma

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 of a vestibular schwannoma

Indication:	**Vestibular schwannoma**
Side:	☐ **Left** ☐ **Right**
Aim of treatment: (Tick as appropriate)	☐ **Tumour control**

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:	☐ You must tell the DVLA if you experience sudden and disabling dizziness or your Vestibular Schwannoma causes other symptoms that will affect your driving.

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. A course of steroids may be required for any of these side effects.

Common 10%–100%	☐ **Tiredness** ☐ **Loss of appetite** ☐ **Headache**
Less common Less than 10%	☐ **Nausea or vomiting** ☐ **Small area of hair loss near the treatment area** ☐ **Facial tingling and numbness** ☐ **Facial weakness** ☐ **Dizziness or feeling unsteady**
Rare Less than 1%	☐ **Facial pain** ☐ **Build-up of fluid within the brain** (hydrocephalus). This may rarely require an operation to insert a shunt
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.

Common 10%–100%	☐ **Increase in size of the vestibular schwannoma due to swelling after radiotherapy** – maximal swelling occurs at around six months ☐ **Hearing loss** – occurs in most patients, the extent depends on pre-treatment hearing
Less common Less than 10%	☐ **Facial tingling and numbness** ☐ **Facial weakness** ☐ **Dizziness** or **feeling unsteady**
Rare Less than 1%	☐ **A benign tumour or different cancer in the treatment area** ☐ **Increased risk of a stroke**
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:

