The Royal College of Radiologists

Radiotherapy consent form for lung cancer

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 to the chest/thorax:** including lung, lymph nodes and thymic tumours
Site and side: (Tick as appropriate)	☐ **Left lung** ☐ **Right lung** ☐ **Bilateral (both sides)** ☐ **Central** ☐ **Left neck** ☐ **Right neck** ☐ **Other (please specify)** _____
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured ☐ **Neo-adjuvant** – treatment given before surgery ☐ **Adjuvant** – treatment given after surgery to reduce the risk of cancer coming back ☐ **Disease control/palliative** – to improve your symptoms and /or help you live longer but not to cure your cancer
Concurrent systemic anti-cancer therapy: (Tick as appropriate)	☐ **Yes with** _____ ☐ **No** (A separate consent form will cover the possible side-effects of this 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.

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%

- ☐ **Mild tiredness**
- ☐ **Mild soreness when swallowing**
- ☐ **Skin soreness, itching and colour changes in treatment area** – redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones
- ☐ **Temporary hair loss in treatment area**

Common
10%–50%

- ☐ **Moderate to severe fatigue**
- ☐ **Mild lung inflammation** which can cause mild breathlessness, cough or changes on your X-ray
- ☐ **Moderate to severe soreness when swallowing**
- ☐ **Mild nausea** – feeling sick

Less common
Less than 10%

- ☐ **Shortness of breath or cough (moderate to severe)** which can affect day-to-day life and is caused by pneumonitis (temporary inflammation of the lungs)
- ☐ **Moderate to severe nausea or vomiting**
- ☐ **Risk of infection** caused by suppressing the immune system and low lymphocyte count
- ☐ **Lhermitte's sign** – temporary changes to the spinal cord presenting as a sudden electric shock like sensation on bending the neck, may occur three to six months after treatment

Rare
Less than 1%

- ☐ **Coughing-up blood** – usually small amounts
- ☐ **Severe skin soreness and colour changes** – redness in white skin tones and yellow/purple/grey appearance in brown and black skin tones
- ☐ **Hospitalisation to help manage your symptoms**
- ☐ **Difficulty swallowing** which may require temporary placement of a feeding tube at the start of treatment or during treatment to support nutrition and hydration
- ☐ **Risk to life** – very rare

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

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

Expected
50%–100%

- ☐ **Lung fibrosis** – scarring of the lung which can be seen on an X-ray or computed tomography (CT) scan which usually does not cause a significant increase in breathlessness

Common
10%–50%

- ☐ **Worsening of shortness of breath and cough**
- ☐ **Long-term irritation of the oesophagus** causing some mild sensation of food sticking or pain

Less common
Less than 10%

- ☐ **Long-term shortness of breath or cough** caused by scarring (fibrosis) of the lung which can be seen on an X-ray or CT scan. This can result in the need for home oxygen
- ☐ **Long-term irritation of the oesophagus** causing more severe sensation of food sticking or pain
- ☐ **Oesophageal stricture** – scarring causing narrowing
- ☐ **Risk of damage to the heart** – risk depends on the position of the tumour
- ☐ **More prone to bone fractures in the radiotherapy treatment area**

Rare
Less than 1%

- ☐ **Chronic lung infections** including abscess
- ☐ **Risk of organ damage** including perforation or fistula
- ☐ **Risk of damage to the nerves to the arms/hands** which can cause pain, numbness or tingling sensations
- ☐ **A different cancer in the treatment area**
- ☐ **Hypothyroidism** – a hormone deficiency, this may require you to take medications
- ☐ **Hyposplenism** – the spleen no longer functions which lowers immunity and may require additional vaccinations and prophylactic antibiotics
- ☐ **Risk to life** – very rare

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 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: