The Royal College of Radiologists

Radiotherapy consent form for rectal 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**
Site: (Tick as appropriate)	☐ **Rectum** ☐ **Pelvic lymph nodes** ☐ **Other** _____
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%

- ☐ **Tiredness**

Common
10%–50%

- ☐ **Bowel frequency** (opening your bowels more often than normal) and **urgency** (a sudden urge to open your bowels)
- ☐ **Looser stools** with more mucous or wind compared to normal
- ☐ **Pain** in the abdomen/back passage
- ☐ **Bleeding** from the rectum
- ☐ **Tenesmus** (feeling the need to open bowels)
- ☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Cystitis/pain when you urinate**
- ☐ **Skin soreness, itching, blistering and colour changes** –redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones
- ☐ **Hair loss in the treatment area**

Less common
Less than 10%

Rare
Less than 1%

- ☐ **Nausea and/or vomiting**

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.

Many of these late side effects, taken in combination, are often referred to as pelvic radiation disease.

Expected
50%–100%

- ☐ **Skin thickening or discoloration** – lighter or darker for any skin tone, or visible blood vessels
- ☐ **Bowel frequency** (opening your bowels more often than normal)
- ☐ **Early menopause**
- ☐ **Infertility** – unable to produce a viable egg and/or for the uterus to be able to carry a fetus.

Common
10%–50%

- ☐ **Mild/moderate bowel incontinence**
- ☐ **Bowel urgency** (a sudden urge to open your bowels)
- ☐ **Bleeding from the rectum**

Less common
Less than 10%

- ☐ **Bowel obstruction/stricture** – a narrowing in your bowel, which may require surgery
- ☐ **Anal stenosis** (narrowing of the anal canal) which may cause pain when opening your bowels. This may also affect your sex life if you receive anal sex. You may be advised to use anal dilators to stretch the anal canal.
- ☐ **Urinary leak or incontinence**
- ☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Cystitis/pain when you urinate**
- ☐ **Pelvis/hip bone thinning and/or fractures**
- ☐ **Vaginal narrowing, shortness or dryness** – this may impact vaginal intercourse, and the comfort and quality of a vaginal examination. You may be advised to use vaginal dilators after treatment which may reduce this risk
- ☐ **Infertility** – unable to produce viable sperm
- ☐ **Change in ejaculate** – reduced amount or dry
- ☐ **Inability to achieve an erection**

Rare
Less than 1%

- ☐ **Bowel/bladder damage which may require surgery** – due to perforation (hole) or fistula (abnormal connection between two parts of your body)
- ☐ **A different cancer in the treatment area**

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:

