The Royal College of Radiologists

Radiotherapy consent form – vaginal vault brachytherapy for gynaecologic 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 theraputic radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy

Radiotherapy type:	**Vaginal vault radiotherapy (brachytherapy)**
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured ☐ **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

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/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%	☐ **Mild pelvic pain**
Less common Less than 10%	☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine) ☐ **Cystitis/pain when you urinate** ☐ **Bowel urgency** (a sudden urge to open your bowels) ☐ **Bowel frequency** (opening your bowels more often than normal) ☐ **Rectal pain/discomfort** ☐ **Looser stools** compared to normal ☐ **Vaginal itching, discharge or light bleeding (spotting)** ☐ **Moderate pelvic pain**
Rare Less than 1%	☐ **Bleeding from your bladder or bowel**
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.

Definite 100%	☐ **Vaginal narrowing, shortening 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.
Expected 50%–100%	☐ **Bleeding from the vagina after using vaginal dilators or vaginal sexual intercourse**
Common 10%–50%	☐ **Urinary frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine) ☐ **Bowel urgency** (a sudden urge to open your bowels) ☐ **Looser stools** compared to normal
Less common Less than 10%	☐ **Cystitis/pain when you urinate** ☐ **Urinary incontinence** including urine leaking when coughing or straining ☐ **Bowel frequency** (opening your bowels more often than normal) ☐ **Rectal pain/discomfort** which may worsen on opening your bowels. This may also affect your sex life if you receive anal sex. ☐ **Bleeding from bowel or bladder** ☐ **Bowel/bladder damage which may require surgery** – due to stricture (narrowing), fistula (abnormal connection between two parts of your body) and may require stoma formation
Rare Less than 1%	☐ **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 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.

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: