The Royal College of Radiologists

# Radiotherapy consent form for breast 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 and side:** (Tick as appropriate) **R = Right / L = Left** | ☐ **Breast** ☐ R ☐ L<br>☐ **Partial breast** ☐ R ☐ L<br>☐ **Chest wall** ☐ R ☐ L<br>☐ **Lymph nodes in armpit (axilla)** ☐ R ☐ L<br>☐ **Lymph nodes in lower neck (supraclavicular fossa)** ☐ R ☐ L<br>☐ **Lymph nodes behind the breastbone (internal mammary chain)** ☐ R ☐ L<br>☐ **Tumour bed boost** ☐ R ☐ L<br>☐ **Other** _____ ☐ R ☐ L |
| **Aim of treatment:** (Tick as appropriate) | ☐ **Curative** – to give you the best chance of being cured<br>☐ **Neo-adjuvant** – treatment given before surgery to shrink the tumour<br>☐ **Adjuvant** – treatment given after surgery to reduce the risk of cancer coming back<br>☐ **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**<br>50%–100% | ☐ **Tiredness**<br>☐ **Temporary hair loss in treatment area** |
| **Common**<br>10%–50% | ☐ **Skin soreness, itching, blistering and colour changes in treatment area**<br>– **white/lighter skin:** pink, red, darker than surrounding area; **brown skin:** maroon or darker than surrounding area; **black skin:** darker than surrounding area, yellow/purple/grey colour changes |
| **Less common**<br>Less than 10% | ☐ **Breast/chest wall/axilla discomfort**<br>☐ **Breast swelling**<br>☐ **Change in breast texture** |
| **Rare**<br>Less than 1% | ☐ **Sore throat**<br>☐ **Skin blistering**<br>☐ **Lung inflammation (pneumonitis)** – which can lead to cough / breathlessness |
| **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%

- ☐ **Breastfeeding** – after breast radiotherapy (and or surgery), you may not produce milk in that breast but the other breast will not be affected

### Common
10%–50%

- ☐ **Skin colour change in the treatment area including:**
  – Lighter or darker for any skin tone
- ☐ **Subtle changes to breast appearance including:**
  – Change to breast size, shape and texture
- ☐ **Breast/chest wall/axilla discomfort including:**
  – Aching and shooting pains
- ☐ **Worsened cosmetic outcome after reconstruction surgery** – which may require the implant to be replaced

### Less common
Less than 10%

- ☐ **Marked change to breast appearance including:**
  – Change to breast size, shape and texture
- ☐ **Breast/chest wall swelling**
- ☐ **Shoulder stiffness**
- ☐ **Swelling (lymphoedema) of the arm** – fluid collecting in the arm which may cause swelling, pain and/or movement difficulties

### Rare
Less than 1%

- ☐ **Skin changes (telangiectasia) in the treatment area** – small visible blood vessels which look like spidery marks
- ☐ **Rib fracture**
- ☐ **Fibrosis (scarring) of the underlying lung** – which can cause breathlessness, cough or changes on X-ray
- ☐ **Increased risk of heart disease in later life**
- ☐ **Brachial plexopathy** – nerve damage which may cause pain, numbness or tingling affecting the arm and shoulder
- ☐ **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 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 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 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:**