The Royal College of Radiologists

Radiotherapy consent form – low dose rate brachytherapy (combined with external beam radiotherapy) for prostate 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:	☐ **Brachytherapy (internal radiotherapy)** ☐ **Brachytherapy (internal radiotherapy) combined with external beam radiotherapy**
Site: (Tick as appropriate)	☐ **Prostate gland/seminal vesicles** ☐ **Pelvic lymph nodes** ☐ **Other (please specify)** _____
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured
Concurrent systemic anti-cancer therapy: (Tick as appropriate)	☐ **Anaesthetic** – an anaesthetist will explain the procedure and risks of this in detail to you
Additional procedures which may be required: (Tick as appropriate)	☐ **Urinary Catheter** – a tube will be inserted into the penis/urethra to drain urine from the bladder, this will usually be removed before you go home ☐ **Blood Transfusion** – rarely there is bleeding requiring a blood transfusion
Radiation Protection	☐ **Radioactivity from the brachytherapy seeds can harm other people for a short time – you will need to follow certain radiation protection constraints which will be discussed with you in detail by your treating team.**

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 or shortly after brachytherapy or radiotherapy and usually resolve within two to six months of finishing treatment. Frequencies are approximate.

Expected
50%–100%

- ☐ **Tiredness**
- ☐ **Urinary frequency** (passing urine more often than normal, including at night) and/or **urgency** (a sudden urge to pass urine) and/or **slower flow** compared to normal
- ☐ **Mild pelvic pain**
- ☐ **Bruising and swelling of the perineum** (area between your scrotum and anus)
- ☐ **Discomfort from prolonged bed rest**
- ☐ **Blood in the urine or semen** (may look dark red/black)
- ☐ **Problems achieving adequate erections**

Common
10%–50%

- ☐ **Cystitis** (pain when you urinate)
- ☐ **Urinary retention and need for a short-term catheter or self-catheterisation** – while swelling settles
- ☐ **Bowel frequency** (opening your bowels more often than normal) and/or **urgency** (a sudden urge to open your bowels)
- ☐ **Looser stools** with more mucous or wind compared to normal
- ☐ **Rectal pain/discomfort** – due to rectal inflammation
- ☐ **Hair loss in the treatment area**

Less common
Less than 10%

- ☐ **Urinary incontinence** (including urine leaking when coughing and straining, some people need to wear pads)
- ☐ **A feeling of not completely emptying your bowels**
- ☐ **Bleeding from your bladder or bowel**
- ☐ **Moderate pelvic pain**
- ☐ **Skin soreness, itching, blistering and colour changes** – **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

Rare
Less than 1%

- ☐ **Heavy bleeding** – which may need further treatment or surgery
- ☐ **Infection of the prostate or bladder needing antibiotics**
- ☐ **Risk of developing a symptomatic blood clot**
- ☐ **Damage to the bowel/bladder needing further surgery** – including a stoma (bag on the abdomen)
- ☐ **Passage of seeds in the urine or ejaculate**

Important information

- ☐ **There is a small possibility of not being able to go ahead with the procedure due to technical reasons even after the anaesthetic has started. Exceedingly rarely, complications can be life-threatening. The risks are different for every individual. Potentially life-threatening complications include those listed on this form, but, other, exceedingly rare side effects may also be life-threatening.**

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 brachytherapy 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%

- ☐ **Infertility** – Radiotherapy will affect your fertility. Please let us know about your plans for having children and we can advise accordingly.
- ☐ **Problems achieving adequate erections**
- ☐ **Changes in ejaculate** – such as reduced amount, altered consistency or blood

Common
10%–50%

- ☐ **Urinary daytime/night-time frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Loss of orgasm**

Less common
Less than 10%

- ☐ **Urinary stricture** (a narrowing in your water pipe which may require surgery)
- ☐ **Urinary daytime/night-time frequency/urgency needing surgery to help symptoms** (trans urethral resection of the prostate)
- ☐ **Incomplete emptying of your bladder or reduced bladder capacity**
- ☐ **Cystitis/pain when you urinate** – due to bladder inflammation
- ☐ **Urinary incontinence** (including urine leaking when coughing and straining, some people need to wear pads)
- ☐ **Urinary retention** – which may require insertion of a temporary or permanent urinary catheter. Rarely surgery (trans-urethral resection) is required to remove the need for a long-term catheter
- ☐ **Bowel frequency** (opening your bowels more often than normal for you)
- ☐ **Bowel urgency** (a sudden urge to open your bowels)
- ☐ **Looser stools** – with more mucous or wind compared to normal
- ☐ **Rectal pain/discomfort** – this may also affect your sex life if you receive anal sex
- ☐ **Bleeding from bladder or bowel**
- ☐ **Intermittent abdominal discomfort**

Rare
Less than 1%

- ☐ **Damage to bladder or bowel needing surgery** – due to perforation (hole), fistula (an abnormal connection between two parts of your body), bowel obstruction (blockage) or severe bleeding
- ☐ **Long-term pain in the perineum and/or at the tip of the penis**
- ☐ **Seeds migration to other organs including outside the pelvis** (extremely rare)
- ☐ **A different cancer in the treatment area**
- ☐ **Pelvis/hip bone thinning and/or fractures**

Radiotherapy to your pelvic lymph nodes

- ☐ **Not applicable to my treatment**

Less Common (Less than 10%)

- ☐ **Lymphoedema** – fluid build-up in your legs and potentially your scrotum

Rare (Less than 1%)

- ☐ **Malabsorption** – problems with nutrient absorption
- ☐ **Neuropathy** – damage to nerves which could cause pain, numbness, or weakness in your legs.

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 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:**

Use of General/Spinal Anaesthesia and procedural sedation

☐ **I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health. I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

Signature:

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: