

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:

Patient unique identifier:

Date of birth:

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.

<p>Expected 50%–100%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Tiredness<input type="checkbox"/> 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<input type="checkbox"/> Mild pelvic pain<input type="checkbox"/> Bruising and swelling of the perineum (area between your scrotum and anus)<input type="checkbox"/> Discomfort from prolonged bed rest<input type="checkbox"/> Blood in the urine or semen (may look dark red/black)<input type="checkbox"/> Problems achieving adequate erections
<p>Common 10%–50%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Cystitis (pain when you urinate)<input type="checkbox"/> Urinary retention and need for a short-term catheter or self-catheterisation – while swelling settles<input type="checkbox"/> Bowel frequency (opening your bowels more often than normal) and/or urgency (a sudden urge to open your bowels)<input type="checkbox"/> Looser stools with more mucous or wind compared to normal<input type="checkbox"/> Rectal pain/discomfort – due to rectal inflammation<input type="checkbox"/> Hair loss in the treatment area
<p>Less common Less than 10%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Urinary incontinence (including urine leaking when coughing and straining, some people need to wear pads)<input type="checkbox"/> A feeling of not completely emptying your bowels<input type="checkbox"/> Bleeding from your bladder or bowel<input type="checkbox"/> Moderate pelvic pain<input type="checkbox"/> Skin soreness, itching, blistering and colour changes – redness in white skin tones and subtle darkening, yellow/purple/grey appearance in brown and black skin tones
<p>Rare Less than 1%</p>	<ul style="list-style-type: none"><input type="checkbox"/> Heavy bleeding – which may need further treatment or surgery<input type="checkbox"/> Infection of the prostate or bladder needing antibiotics<input type="checkbox"/> Risk of developing a symptomatic blood clot<input type="checkbox"/> Damage to the bowel/bladder needing further surgery – including a stoma (bag on the abdomen)<input type="checkbox"/> Passage of seeds in the urine or ejaculate
<p>Important information</p>	<p><input type="checkbox"/> 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.</p>
<p>Specific risks to you from your treatment</p>	
<p>I confirm that I have had the above side-effects explained.</p>	
	<p>Patient initials <input type="text"/></p>

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.

<p>Expected 50%–100%</p>	<p><input type="checkbox"/> Infertility – Radiotherapy will affect your fertility. Please let us know about your plans for having children and we can advise accordingly.</p> <p><input type="checkbox"/> Problems achieving adequate erections</p> <p><input type="checkbox"/> Changes in ejaculate – such as reduced amount, altered consistency or blood</p>
<p>Common 10%–50%</p>	<p><input type="checkbox"/> Urinary daytime/night-time frequency (passing urine more often than normal) and urgency (a sudden urge to pass urine)</p> <p><input type="checkbox"/> Loss of orgasm</p>
<p>Less common Less than 10%</p>	<p><input type="checkbox"/> Urinary stricture (a narrowing in your water pipe which may require surgery)</p> <p><input type="checkbox"/> Urinary daytime/night-time frequency/urgency needing surgery to help symptoms (trans urethral resection of the prostate)</p> <p><input type="checkbox"/> Incomplete emptying of your bladder or reduced bladder capacity</p> <p><input type="checkbox"/> Cystitis/pain when you urinate – due to bladder inflammation</p> <p><input type="checkbox"/> Urinary incontinence (including urine leaking when coughing and straining, some people need to wear pads)</p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> Bowel frequency (opening your bowels more often than normal for you)</p> <p><input type="checkbox"/> Bowel urgency (a sudden urge to open your bowels)</p> <p><input type="checkbox"/> Looser stools – with more mucous or wind compared to normal</p> <p><input type="checkbox"/> Rectal pain/discomfort – this may also affect your sex life if you receive anal sex</p> <p><input type="checkbox"/> Bleeding from bladder or bowel</p> <p><input type="checkbox"/> Intermittent abdominal discomfort</p>
<p>Rare Less than 1%</p>	<p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> Long-term pain in the perineum and/or at the tip of the penis</p> <p><input type="checkbox"/> Seeds migration to other organs including outside the pelvis (extremely rare)</p> <p><input type="checkbox"/> A different cancer in the treatment area</p> <p><input type="checkbox"/> Pelvis/hip bone thinning and/or fractures</p>
<p>Radiotherapy to your pelvic lymph nodes</p>	<p><input type="checkbox"/> Not applicable to my treatment</p> <p>Less Common (Less than 10%)</p> <p><input type="checkbox"/> Lymphoedema – fluid build-up in your legs and potentially your scrotum</p> <p>Rare (Less than 1%)</p> <p><input type="checkbox"/> Malabsorption – problems with nutrient absorption</p> <p><input type="checkbox"/> Neuropathy – damage to nerves which could cause pain, numbness, or weakness in your legs.</p>
<p>Specific risks to you from your treatment</p>	
<p>I confirm that I have had the above side-effects explained.</p>	
<p style="text-align: right;">Patient initials <input style="width: 80px; height: 25px;" type="text"/></p>	

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.

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:

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:

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: