

DISCLOSURE AND CONSENT FOR RADIATION THERAPY

As a patient, you have the right to be informed about your condition and the recommended radiation therapy procedure to be used to treat your condition. This disclosure is not meant to alarm you; however, there are certain risks which are associated with radiation therapy. This explanation is intended to inform you of those risks so that you may give or withhold your consent to the recommended procedure on an informed basis. Please carefully review the following and if you choose to proceed with this treatment, sign this consent in the space below:

I (we) hereby voluntarily request and authorize Dr. _____ as my physician, and such associates, technicians and the health care providers as they may deem necessary to treat my condition which has been explained to me (us) as: _____

I (we) understand that my condition may be treated with external beam radiation therapy alone, with internal radiation implant alone or with both or in planned combination with surgery and/or chemotherapy.

I (we) understand that the following radiation therapy procedure(s) are planned for me and I (we) consent to and authorize these procedure(s) (specify technique and site):

I (we) further authorize the taking of photographs or placing of tattoo or skin marks necessary for treatment.

ALL FEMALES MUST COMPLETE: I (we) understand that radiation can be harmful to the unborn child.

I am, I could be, I am not pregnant.

I (we) understand that there may be side-effects or complications from radiation therapy, either during or shortly after the course of treatment ("early reactions"), or some time later ("late reactions"). Any of the side-effects or complications may be temporary or permanent.

These reactions may be worsened by chemotherapy or surgery before, during or after radiation therapy or by previous radiation therapy to the same area. Early and late reactions which could occur as a result of the procedure(s) are listed below. With few exceptions, these reactions affect only the areas actually receiving radiation therapy.

(Place list(s) for specific region or regions of the body receiving radiation therapy here. A single form may be used for multiple regions or a separate form may be used for each separate region.)

The nature and purpose of the proposed procedure, the alternative methods of treatment, and the risks and hazards if treatment is withheld have been explained to me (us) by my physician. I (we) have had an opportunity to discuss these matters with my physician and to ask questions about my condition, alternative methods of treatment and the proposed procedure(s). I (we) understand that no warranty or guarantee has been made to me (us) as to result or cure.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

DATE: _____ **TIME:** _____ **A.M./P.M.**

WITNESS:

Signature

Name (Print)

Address (Street or P. O. Box)

City, State, Zip Code