CANCER CENTER
UMC HEALTH SYSTEM

**Patient Label Here**

**DISCLOSURE AND CONSENT – RADIATION THERAPY & DEVICE PLACEMENT**

**TO THE PATIENT**: You have the right as a patient 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:

1. I (we) voluntarily request Doctor(s)_____as my physician(s), and such associates, technical assistants and other health care providers as they may deem necessary to treat my condition which has been explained to me (us) as (lay terms)**:** _____
_____

2. 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.

3. I understand that the following radiation therapy procedure(s) are planned for me and I (we) consent to and authorize these procedures(s) (**specify technique & region**): _____
_____

| | | |
|---|---|---|
| Region (s): | ☐ ABDOMEN | ☐ BREAST |
| | ☐ CENTRAL NERVOUS SYSTEM (Brain/Spine) | |
| | ☐ EXTREMITY | ☐ HEAD & NECK |
| | ☐ FEMALE PELVIS | ☐ MALE PELVIS |
| | ☐ SKIN | ☐ THORAX |
| | ☑ **GYNECOLOGICAL BRACHYTHERAPY (Internal Radiation Therapy)** | |

4. Please initial _____**Yes**_____**No**

I consent to the use of blood and blood products as deemed necessary. I (we) understand that the following risks and hazards may occur in connection with the use of blood and blood products:

a. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
b. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys and immune system.
c. Severe allergic reaction, potentially fatal.

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

6. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following hazards may occur in connection with this particular procedure: Pain, severe bleeding, infection, uterine perforation (which may require surgical intervention and/or use of blood products), inability to complete procedure, hospitalization

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

Radiation Brachytherapy (cont.)

8. 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: **SEE ATTACHMENT FOR SPECIFIC EARLY AND LATE REACTIONS**. With few exceptions, these reactions affect only the areas actually receiving radiation therapy.

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

( ) I am pregnant ( ) I could be pregnant ( ) I am not pregnant

_____**INITIAL IF APPLICABLE:**

**I HAVE AN IMPLANTED ELECTRONIC DEVICE** (such as a pacemaker, defibrillator or nerve stimulator). I understand radiation to the device can cause malfunction of the device.

9. 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.

10. I (we) consent to the taking of still photographs, motion pictures, videotapes, or closed circuit television during this procedure.

11. I (we) give permission for a corporate medical representative to be present during my procedure on a consultative basis.

12. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, potential benefits, risks, or side effects, including potential problems related to recuperation and the likelihood of achieving care, treatment, and service goals. I (we) believe that I (we) have sufficient information to give this informed consent.

13. I (we) certify this form has been fully explained to me and that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

If I (we) do not consent to any of the above provisions, that provision has been corrected.

I have explained the procedure/treatment, including anticipated benefits, significant risks and alternative therapies to the patient or the patient's authorized representative.

_____ _____ A.M. (P.M.) _____

Date Time Printed name of provider/agent Signature of provider/agent

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_____ A.M. (P.M.)

Date Time

_____

*Patient/Other legally responsible person signature Relationship (if other than patient)

_____

*Witness Signature Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No_____

Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No_____

Printed name of interpreter Date/Time

****CONSENT VALID FOR ONE YEAR FROM DATE OF SIGNATURE****

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# CONSENT FOR EXAMINATION OF PELVIC REGION

For pelvic examinations under anesthesia for student training purposes.

A "pelvic examination" means a physical examination by a health care practitioner of a patient's external and internal reproductive organs, genitalia, or rectum.

During your procedure, your health care practitioner, or a resident designated by your health care practitioner, may perform or observe a pelvic examination on you while you are anesthetized or unconscious. This is a part of the procedure to which you have consented.

***With your further written consent,*** your health care practitioner may perform, or allow a medical student or resident to perform or observe, a pelvic examination on you while you are anesthetized or unconscious, not as part of your procedure, but for educational purposes.

The pelvic examination is a critical tool to aid in the diagnosis of women's health conditions. It is an important skill necessary for students to master.

Your safety and dignity is of highest importance. All students and residents are under direct supervision during pelvic examinations.

**You may consent or refuse to consent** to an educational pelvic examination. Please check the box to indicate your preference:

☐ I consent ☐ I DO NOT consent to a medical student or resident being present to **perform** a pelvic examination for training purposes.

☐ I consent ☐ I DO NOT consent to a medical student or resident being present to **observe or otherwise be present** at the pelvic examination for training purposes, either in person or through secure, confidential electronic means.

_____ _____ **A.M. (P.M.)**
**Date** **Time**

_____
***Patient/Other legally responsible person signature** **Relationship (if other than patient)**

_____ _____ **A.M. (P.M.)** _____ _____
**Date** **Time** **Printed name of provider/agent** **Signature of provider/agent**

_____
*Witness Signature Printed Name

☐ UMC 602 Indiana Avenue, Lubbock, TX 79415 ☐ TTUHSC 3601 4th Street, Lubbock, TX 79415
☐ OTHER Address: _____
Address (Street or P.O. Box) City, State, Zip Code

Interpretation/ODI (On Demand Interpreting) ☐ Yes ☐ No_____
Date/Time (if used)

Alternative forms of communication used ☐ Yes ☐ No_____
Printed name of interpreter Date/Time

Date procedure is being performed: _____

# RADIATION THERAPY-RISKS
# FEMALE PELVIS

## A. Early reactions

1. Inflammation of bowel causing cramping and diarrhea.
2. Inflammation of rectum and anus causing pain, spasm, discharge, bleeding.
3. Bladder inflammation causing burning, frequency, spasm, pain, bleeding
4. Skin changes: redness, irritation, scaliness, blistering or ulceration, discoloration, thickening, and hair loss.
5. Disturbance of menstrual cycle.
6. Vaginal discharge, pain, irritation, bleeding.
7. Depression of blood count leading to increased risk of infection and/or bleeding.
8. In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.
9. In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

## B. Late reactions

1. Bowel damage causing narrowing or adhesions of the bowel with obstruction, ulceration, bleeding, chronic diarrhea or poor absorption of food elements and may require surgical correction or colostomy.
2. Bladder damage with loss of capacity, frequency of urination, blood in urine, recurrent urinary infections, pain or spasm which may require urinary diversion and/or removal of bladder.
3. Changes in skin texture, discoloration, permanent hair loss, and scarring of skin.
4. Bone damage leading to fractures.
5. Ovarian damage causing infertility, sterility or premature menopause.
6. Vaginal damage leading to dryness, shrinkage, pain, bleeding, and sexual dysfunction.
7. Swelling of the genitalia or legs.
8. Nerve damage causing pain, loss of strength or feeling in legs and/or loss of control of bladder or rectum.
9. Fistula between the bladder and/or bowel and/or vagina.
10. In children, there may be additional late reactions:
    a) Disturbances of bone and tissue growth.
    b) Bone damage to pelvis and hips causing stunting of bone growth and/or abnormal development.
    c) Secondary cancers developing in the irradiated area.

Patient Label Here

# Gynecological Brachytherapy (Internal Radiation Therapy) Cylinder

| About the treatment & what to expect: | Preparation for treatment: |
|---|---|
| **Brachytherapy is a type of internal radiation that is used to destroy cancer cells and shrink tumors**<br>• Procedure will require a signed consent<br>• Foley catheter will be placed (per provider preference)<br>• Your provider will place a tube called a catheter or implant into your body<br>• Radiation will be delivered through thin cables which will be connected to a high radioactive source<br>• CT scan will verify placement of the applicator<br>• You will be expected to lie flat for 1-2 hours and it is very important to lie very still with no movement below the waist<br>• You will be monitored closely throughout your treatment by your healthcare team<br><br>**Common Side Effects:**<br>• Bladder irritation<br>• Cramping<br>• Diarrhea<br>• Vaginal discharge<br>• Vaginal dryness<br>• Fatigue | **Pre Procedure Instructions:**<br>• You may take all scheduled medication with a light meal before your treatment<br>• Present with a full bladder for treatment (per provider preference)<br><br>**Post Procedure:**<br>• Get adequate rest<br>• Post procedure instructions will be given by your nurse which will include post procedure care<br>• Inform your provider of any post procedure complications including: Temp greater than 101, heavy vaginal bleeding, abdominal pain unrelieved by pain medication, a change in urination or bowel movement.<br><br>**Note: You will not be radioactive**<br><br>** Please leave personal belongings at home or with your family** |

Patient Label Here

# Gynecological Brachytherapy (Internal Radiation Therapy) Tandem & Ovoid

| About the procedure & what to expect: | Preparation for procedure: |
|---|---|
| **Brachytherapy is a type of internal radiation that is used to destroy cancer cells and shrink tumors**<br>• Inform your provider of any allergies to medications you may have<br>• Inform your provider if you have a history of obstructive sleep apnea (stop breathing or struggle to breathe while you sleep)<br>• Procedure will require a signed consent<br>• Foley catheter and IV will be placed<br>• Moderate sedation medications will be given which can cause a depressed level of consciousness<br>• Your provider will place an applicator referred to as a tandem and ovoid or ring into your body<br>• Radiation treatment will be delivered through thin cables which will be connected to a high radioactive source<br>• Ultrasound and CT scan will verify placement of the applicator<br>• You will be expected to lie flat for 3-4 hours and it is very important to lie very still with no movement below the waist<br>• You will be monitored closely throughout your procedure by your healthcare team<br>**Common Side Effects:**<br>• Burning upon urination<br>• Pelvic cramping<br>• Diarrhea<br>• Vaginal discharge<br>• Vaginal dryness<br>• Fatigue | **Pre Procedure Instructions:**<br>• The day prior to your procedure, begin a clear liquid diet and take a stool softener (per provider preference)<br>• An empty bowl on the day of the procedure is preferred<br>• Do not eat or drink anything after midnight or 6am prior to your procedure (time dependent on when procedure is scheduled)<br>• Medications may be taken with a sip of water<br>• Post procedure instructions will be reviewed with responsible adult prior to procedure start<br>**Post Procedure:**<br>• Ensure someone is available to drive you home<br>• You may feel drowsy after your procedure<br>• Get adequate rest<br>• Begin taking clear liquids after your procedure and advance your diet as tolerated<br>• Post procedure instructions will be given by your nurse which will include post procedure care<br>• Inform your provider of any post procedure complications including: temp > 101, heavy vaginal bleeding, abdominal pain unrelieved by pain medication, a change in urination or bowel movement<br>**Note: You will not be radioactive**<br>****Please leave personal belongings at home or with your family**** |

## Caring for yourself during radiation treatment

Follow your provider's orders. If you are unsure of the treatment you are receiving, ask your provider or radiation team. Side effects are not the same for all patients. **Note: radiation side effects are limited only to the area being treated**. Notify your provider if you experience new symptoms.

**For questions or concerns related to radiation treatment, contact your provider or nurse at (806) 775-8568. After 5:00 pm, on weekends and holidays, please call 806 775-8600. In the event of an emergency, call 911 or go to the nearest emergency center.**

***Our goal is to provide you with very good care.***
***Thank you for choosing UMC Cancer Center Radiation Oncology***

***Service is our passion!***