CANCER CENTER
UMC HEALTH SYSTEM

Patient Label Here

DISCLOSURE AND CONSENT – RADIATION THERAPY

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

5. 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.

6. 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.

7. 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.

Radiation Therapy (cont.)

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.

8. I (we) authorize University Medical Center to preserve for educational and/or research purposes, or for use in grafts in living persons, or to otherwise dispose of any tissue, parts or organs removed except _____None_____

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

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

11. 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.

12. 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

_____ _____ 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****

CANCER CENTER
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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
HEAD AND NECK

A. Early reactions

1. Reduced and sticky saliva, loss of taste and appetite, altered sense of smell, and nausea.
2. Sore throat, difficulty swallowing, weight loss, and fatigue.
3. Skin changes: redness, irritation, scaliness, blistering or ulceration, color change, thickening, and hair loss.
4. Hoarseness, cough, loss of voice and swelling of airway.
5. Blockage and crusting of nasal passages.
6. Inflammation of ear canal, feeling of "stopped up" ear, hearing loss, dizziness.
7. Dry and irritable eye(s).
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. Dry mouth and altered sense of smell and loss of taste.
2. Tooth decay and gum changes.
3. Bone damage, especially in jaws.
4. Stiffness and limitation of jaw movement.
5. Changes in skin texture, discoloration, permanent hair loss and scaring of skin.
6. Swelling of tissues particularly under the chin.
7. Throat damage causing hoarseness, pain, difficulty breathing and swallowing.
8. Eye damage causing dry eye(s), cataract, loss of vision, or loss of eye(s).
9. Ear damage causing dryness of ear canal, fluid collection in middle ear, and hearing loss.
10. Brain, spinal cord or nerve damage causing alteration of thinking ability, memory and loss of strength, feeling or coordination in any part of the body.
11. Pituitary or thyroid gland damage requiring long-term hormone replacement therapy.
12. In children, there may be additional late reaction as follows:
    a) Disturbances of bone and tissue growth.
    b) Bone damage to face causing abnormal development.
    c) Brain damage causing a loss of intellectual ability, learning capacity and reduced intelligence quotient (I.Q.)
    d) Secondary cancers developing in the irradiated area.

Patient Label Here

SIDE EFFECTS OF RADIATION TREATMENT TO THE HEAD & NECK

Possible Side Effects	Side Effect Management
• Sore Throat • Difficulty swallowing • Thick mucus / Sticky saliva • Swelling in the gums, throat, or neck • Mouth sores • Loss of taste and appetite • Weight loss • Fatigue and weakness • Skin changes; redness, irritation, dryness, change in skin color, skin thickening • Hair loss to the treatment site • Inflammation of ear canal, "stopped up" ear, hearing loss, or dizziness • Tooth decay **Possible Long Term Side Effects:** • Inability to swallow • Dry mouth **Note:** • You will not be radioactive • You may eat, drink, and take scheduled medications prior to your daily treatment • Exercise as tolerated	• Hydrate well • Care for teeth using a soft toothbrush or oral swab after each meal • Rinse mouth with 1 cup warm water, ½ tsp salt and ½ tsp baking soda • Eat a healthy well balanced diet • Drink nutritional supplements if no appetite • Moisturize treated area with lubricant approved by your provider • Use mild soap when bathing; avoid drying agents • No harsh rubbing or scrubbing to the treatment site • Avoid extreme hot and cold temperatures to the treatment site • Use sunscreen SPF 30 or higher • Cover with hat or scarf post radiation treatment for 1 year • Avoid mouthwash containing alcohol • Avoid smoking and drinking alcohol

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!