The Royal College of Radiologists

Radiotherapy consent form for head and neck sarcoma

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:	**External beam radiotherapy**
Site and side: (Tick as appropriate)	☐ **Face** ☐ **Scalp** ☐ **Sinuses and nasal cavity** ☐ **Parotid** ☐ **Oral Cavity** ☐ **Other (specify)** _____ ☐ **Left neck** ☐ **Right neck** ☐ **Left** ☐ **Right**
Aim of treatment: (Tick as appropriate)	☐ **Neo-adjuvant** – treatment given before surgery ☐ **Adjuvant** – treatment given after surgery to reduce the risk of cancer coming back ☐ **Definitive** – without surgery ☐ **Disease control/palliative** – to improve your symptoms and/or help you live longer but not to cure your cancer

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

Expected
50%–100%

- ☐ **Skin soreness, itching, blistering and colour changes in treatment area** – **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.
- ☐ **Irritation in the lining of the nose or blocked nose**
- ☐ **Sore throat**
- ☐ **Oral ulceration**
- ☐ **Loss and / or change of taste**
- ☐ **Pain in the mouth and / or throat** which can cause problems with swallowing
- ☐ **Red or watery eye**
- ☐ **Hair thinning or loss in the treatment area**
- ☐ **Tiredness**
- ☐ **Anxiety, low mood, or poor sleep**

Common
10%–50%

- ☐ **Dry mouth**
- ☐ **Thickened secretions**
- ☐ **Mouth infections** including oral thrush
- ☐ **Difficulty swallowing** which may require temporary placement of a feeding tube at the start of treatment or during treatment to support nutrition and hydration
- ☐ **Nausea** – feeling sick
- ☐ **Loss of appetite** which may lead to weight loss
- ☐ **Temporary hearing loss and/or earache**
- ☐ **Changes in / loss of sense of smell**
- ☐ **Voice changes**
- ☐ **Swelling of the voicebox**
- ☐ **Risk of hospital admission**

Less common
Less than 10%

- ☐ **Vomiting**
- ☐ **Chest infection** which may be due to food and/or secretions going down the windpipe
- ☐ **Dehydration** as a result of reduced oral intake
- ☐ **Lhermitte's sign** – temporary changes to the spinal cord presenting as a sudden electric shock like sensation on bending the neck, may occur three to six months after treatment

Rare
Less than 1%

- ☐ **Risk to life**

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 radiotherapy and may be permanent. Frequencies are approximate.

Expected
50%–100%

- ☐ **Permanent skin colour change in the treatment area** – usually lighter or darker for any skin tone
- ☐ **Dry mouth**
- ☐ **Altered taste or loss of taste** – with possibility of some recovery over 18 months
- ☐ **Permanent dryness of nose**
- ☐ **Nasal crusting**

Common
10%–50%

- ☐ **Lymphoedema** – swelling of the face, chin and/or neck caused by fluid (lymph) build up, which may cause discomfort
- ☐ **Permanent skin texture changes in the treated area** – thicker or thinner skin
- ☐ **Small visible blood vessels which look like spidery marks in the treatment area**
- ☐ **Permanent hair loss in and around the treatment area** – if hair starts to regrow it may be patchy
- ☐ **Hypothyroidism** – under-active thyroid gland, which may require you to take medication
- ☐ **Cataract** – Clouding in the lens of the eye, which may require surgery to correct

Less common
Less than 10%

- ☐ **Dry eye**
- ☐ **Visual changes**
- ☐ **Nasal regurgitation** – food or fluid coming up into the nose whilst eating or drinking
- ☐ **Loss of smell**
- ☐ **Changes in hearing which may include: hearing loss, tinnitus (ringing or unusual sounds in the ear) or a feeling of fullness in the ear**
- ☐ **Voice changes**
- ☐ **Dental problems**
- ☐ **Trismus** – painful or reduced opening of the mouth
- ☐ **Osteoradionecrosis of the jaw** – damage to the jawbone
- ☐ **Swallowing problems** – with risk of long-term/permanent feeding tube requirement
- ☐ **Increased risk of stroke**
- ☐ **Pituitary dysfunction** – your pituitary gland not producing enough hormones which may require you to take medication to replace the hormones

Rare
Less than 1%

- ☐ **Permanent damage to brainstem and/or spinal cord** – which may cause change in sensation or weakness, and/or change in bowel/bladder function. Exceptionally rarely this may cause paralysis, permanent disability, or death.
- ☐ **Permanent damage to nerves to the face, arm or hand** – which may cause pain, numbness or tingling
- ☐ **Increased risk of a different cancer in the treatment area**
- ☐ **Injury to the brain (radio-necrosis)** – a small area of irreversible change in the brain, which may be symptomatic or identified on scans. This may require treatment with steroids or rarely requires surgery.
- ☐ **Risk to life**

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 confirm that there is no risk that I could be pregnant.

☐ I understand that I should not become pregnant during treatment.

Note: if there is any possibility of you being pregnant you must tell your hospital doctor/health professional before your treatment as this can cause significant harm to an unborn fetus. Testosterone and other hormone treatments are not contraception.

☐ 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:

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: