RADIATION ONCOLOGY DEPARTMENT
CONSENT FOR RADIATION THERAPY TO THE AREA OF THE BREAST AND ADJACENT LYMPH NODES

PATIENT NAME: ____________________________________  MR#:  _________________ (Print name)

I hereby authorize Dr. ____________________ to administer Radiation Oncology Treatment to my:

☐ Left breast & adjacent lymph nodes    ☐ Right breast and adjacent lymph nodes

The undersigned patient acknowledges that he/she has been given sufficient information to make an informed decision about consenting to the Radiation Treatment and simulation/planning activities associated with treatment. Specifically, the undersigned has been told about the potential benefits, risks and alternatives to the Radiation Treatment and consequences to him/her if no Radiation Treatment is given.

I understand that the Radiation Treatment will be delivered to the above site, and I further understand that my physician will continue such Radiation Treatment as long as he/she believes it to be medically indicated. The potential benefit from this Radiation Treatment is that it may significantly lower the risk of recurrence of the tumor in the treatment region and/or alleviate the troubling symptoms as discussed.

I acknowledge that I have been told and understand that the Radiation Treatment may cause any number of the serious side effects listed on the back of this form. While the likelihood of their occurrence is not high, we will take necessary precautions to prevent or minimize their occurrence. I understand, however, that despite any and all of the precautions taken, it is still possible that these and other unexpected complications may still occur.

In connection with the Radiation Treatment, I authorize the marking of my skin with tiny permanent marks to aid in localizing the area of my body to be treated.

Having read this form and talked with my physicians, I understand the potential benefits and risks of the Radiation Treatment. I also understand that reasonable types of alternative treatment might include chemotherapy, surgery or no treatment. No guarantees or promises have been made to me regarding the outcome of the Radiation Treatment.

I also authorize the Hospital and the above-named physician(s) to photograph, video and/or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

I consent to have the radiation simulation/planning and treatments described above administered under the direction of my primary radiation oncologist, who may be assisted by other Hospital affiliated physicians, nursing, and technical staff.

FOR FEMALES ONLY: __________(initials)
I am not pregnant now and have no reason to suspect that I am pregnant.
I understand there is a potential risk to the fetus if I become pregnant during treatment.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

Patient’s initials: ______________
POSSIBLE SIDE EFFECTS OF RADIATION THERAPY TREATMENT 
TO THE AREA OF THE BREAST AND ADJACENT LYMPH NODES

I understand that any treatment may include side effects as well as the risk of more serious complications. It has been explained to me that each patient reacts differently to the treatment and that I may experience none, some, or all of these reactions to a varying degree of intensity. I further understand that if other types of treatment are given in conjunction with radiation therapy, some of the reactions may be greater or more frequent than if radiation therapy alone is given.

Reactions may include, but not necessarily limited to the following:

### Reactions during Radiation Therapy

**Common:**
- Skin reddening & irritation in the treated area
- Skin darkening in treated area
- Tiredness
- Occasional aches and pains in the breast
- Temporary hair loss under the arm
- Small regions of skin blistering in the treated area
- Mild breast swelling

**Uncommon:** occurring in 1-5% of people treated
- Extensive skin blistering or peeling in the treated area
- Decreased blood cell count

### Long Term Reactions

**Common:**
- Occasional discomfort and sensitivity in the treated area
- Mild increased firmness of the treated breast
- Mild swelling of the treated breast
- Minor shrinkage of the treated breast
- Skin color change in the treated area
- Scarring of a small amount of lung just under the chest wall (this rarely causes symptoms)

**Uncommon:** occurring in 1-5% of people treated
- Significant increase in firmness of the treated breast
- Arm swelling

**Rare:** occurring in less than 1% of people treated
- Rib fractures in the treated area
- There may be an increase in the risk of heart attack when the left breast is treated
- Significant shrinkage of the treated breast
- Lung inflammation
- Damage to the nerves in the arm
- Inflammation of the lining of the heart (only if left breast treated)
- Cancer in the treated area caused by radiation
- Painful ulceration or infection in treated area

The possible reactions to, and side effects of, the treatment have been explained to me. My questions have been answered.

<table>
<thead>
<tr>
<th>Radiation Oncologist</th>
<th>Date: ________ Time: ________</th>
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</thead>
<tbody>
<tr>
<td>Patient or legally authorized representative</td>
<td>Date: ________ Time: ________</td>
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<tr>
<td>Interpreter responsible for explaining procedures and special treatment:</td>
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<tr>
<td>Interpreter</td>
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</tbody>
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PATIENT UNABLE TO SIGN PRIOR TO PICTURE (□) BECAUSE: ______

<table>
<thead>
<tr>
<th>Physician</th>
<th>Date</th>
<th>Time</th>
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<tbody>
<tr>
<td>Witness</td>
<td>Date</td>
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