RADIATION ONCOLOGY DEPARTMENT

Consent for Ra223 Therapy

PATIENT NAME: ____________________________________  MR#: ______________

I hereby authorize Dr._____________________________ to perform the proposed Radiation Oncology Treatment of Ra223 Therapy to my Whole Body.

I consent to have the Ra223 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. I understand that there may be unforeseen circumstances that are encountered while performing the above listed special procedure that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed procedure: (i) the nature and purpose of the proposed treatment; (ii) the foreseeable risks and consequences of the proposed treatment, including the risk that the proposed treatment may not achieve the desired objective; (iii), and the alternatives to the proposed treatment might include chemotherapy, surgery or no treatment, and the associated risks and benefits to such alternatives.

Specifically, in obtaining my informed consent to the special procedure, I have been informed of the following reasonably foreseeable risks:

**Reactions following Ra223**
- Low blood counts
- Peripheral edema
- Diarrhea
- Nausea/vomiting

**Long Term Reactions**
- Cancer caused by radiation

**Uncommon: occurring in 1-5% of people treated:**
- Injection site pain and swelling
- Kidney damage

FOR FEMALES ONLY:
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.

__________ Patient initials

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I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed treatment.

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

______________________________ M. D.  Signed: ________________________________
(Patient or legally authorized representative)

Date: ___________ Time:___________  Date: ___________ Time:___________

Interpreter responsible for explaining procedures and special treatment:

_____________________________________ (Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [ ] BECAUSE:

____________________________________ M.D.  Date: ___________ Time:___________

____________________________________ Witness  Date: ___________ Time:___________