



## RADIATION ONCOLOGY DEPARTMENT

### CONSENT FOR RADIATION THERAPY HODGKIN'S / NON-HODGKIN'S LYMPHOMA MANTLE

PATIENT NAME: \_\_\_\_\_  
Print name)

MR#: \_\_\_\_\_

TO THE PATIENT: You have been given information about your condition and the recommended radiation therapy. This consent form is a written confirmation of such discussion so that you will be better informed to give or withhold your consent to the proposed course of therapy.

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My condition and the need for treatment have been explained to me. Alternative treatments have been discussed with me, and I understand the likely consequences if no treatment is given.

Radiation therapy has been proposed for my treatment. I understand this will be delivered to the lymph node areas in my chest, axilla, and the neck and will take approximately 5 weeks. The potential benefit from this treatment is that it will significantly lower the risk of recurrence of the lymphoma.

Side effects from radiation therapy may include mild tiredness and some damage to normal tissues in the area being treated, such as skin reactions. I understand there is a small risk of significant complications and the complete listing on the back of this form has been explained to me. I understand that despite all precautions taken, unexpected complications may occur.

I authorize the drawing of blood tests from time to time as ordered by my physician.

I authorize the marking of my skin with tiny permanent marks to aid in localizing the area to be treated.

I consent to have my treatment and follow up records reviewed in the future as part of a study. I understand that my confidentiality will be maintained at all times.

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

Patients initials: \_\_\_\_\_



**POSSIBLE SIDE EFFECTS OF RADITATION THERAPY TREATMENT TO THE CHEST, AXILLA, AND NECK AREA**

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 be limited to the following:

**Immediate Reactions**

Common:

- Tiredness
- Skin reddening & irritation
- Swallowing difficulties
- Nausea & Vomiting
- Decreased blood cell count
- Temporary hair loss
- Shingles (Herpes Zoster)
- Weight loss
- Temporary changes in taste
- Dryness of the mouth

Uncommon:

- Skin blistering

**Long Term Reactions**

Common:

- Thyroid dysfunction
- Shingles (Herpes Zoster)
- An electric shock sensation on bending the neck (Lhermitte's syndrome)

Uncommon:

- Tumors caused by radiation

**NOTE:** In particular, breast cancer caused by radiation is related to patient age, and in young females, the risk is much higher than in older females.

- Dental cavities
- Inflammation and scarring of the lung

Rare:

- Inflammation of the heart

Extremely Rare:

- Lung collapse
- Heart attack
- Irregular heart beat
- Spinal cord injury
- Lung scarring with chronic shortness of breath
- Nerve damage
- Decreased cardiac function

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

Radiation Oncologist \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient or legally authorized representative \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter responsible for explaining procedures and special treatment:

Interpreter \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_

PATIENT UNABLE TO SIGN PRIOR TO PICTURE ( <input type="checkbox"/> ) BECAUSE: _____	
_____ Physician	Date: _____ Time _____
_____ Witness	Date: _____ Time _____