Hartford Hospital
A Hartford HealthCare Partner

6816

RADIATION ONCOLOGY DEPARTMENT

CONSENT FOR RADIATION THERAPY TO PARTIAL BREAST ONLY

PATIENT NAME: ______________________________ MR#: __________
(Print name)

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

❑ **Left Breast** ❑ **Right Breast**

TO THE PATIENT: You have been given information about your condition and the recommended radiation therapy.

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Radiation therapy has been proposed for my treatment. I understand this will be delivered only to the part of my breast surrounding the region of surgery, and that the radiation will be given within a much shorter period of time than usual (this form of treatment is called accelerated partial breast irradiation (APBI). I understand my physician will continue such treatment as he/she may deem advisable. The potential benefit from this treatment is that it will significantly lower the risk of recurrence of cancer in the breast. I understand that a different form of radiation therapy known as whole breast irradiation (WBI) has been used for women in this setting for many years and is an established treatment that has documented excellent rates of long-term effectiveness and safety. In contrast, accelerated partial breast irradiation (APBI) is a relatively new method, and thus its long-term effectiveness and safety (beyond 5-6 years) are not yet fully known. Treatment with APBI may not reduce the risk of cancer recurrence within the breast to the same degree that WBI does. Recurrence of breast cancer may require mastectomy and chemotherapy and involves the risk for spread of cancer to other parts of the body and death from that. It may be that the risk of long term complications is greater with APBI than with WBI.

I authorize the marking of my skin with tiny permanent or temporary 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 treatments have been discussed (no radiation therapy, whole breast radiation therapy, mastectomy). 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.

Patient's initials: ______________

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POSSIBLE SIDE EFFECTS OF RADIATION THERAPY TREATMENT TO THE AREA OF THE PARTIAL BREAST ONLY (APBI)

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, darkening and irritation near the treatment site
- Infection at the treatment site
- Mild pain at the treatment site
- Swelling at the treatment site
- Fatigue

Uncommon: occurring in 1-5% of treated people

- Extensive skin blistering or peeling near the treatment site
- Significant pain at the treatment site
- Significant increase in firmness of the breast at the treatment site

Long Term Reactions

Common:

- Occasional discomfort and sensitivity at the treatment site
- Mild increased firmness of the breast at the treatment site
- Mild swelling of the treated breast
- Minor shrinkage of the treated breast
- Skin color change near the treatment site
- Scarring of a small amount of lung just under the chest wall near the treatment site (this rarely causes symptoms)

Rare: occurring in less than 1% of people treated

- Rib fractures near the treatment site
- Loss or impairment of nerve function near the treatment site
- Significant shrinkage of the treated breast
- Lung inflammation
- Skin ulceration near the treatment site
- Inflammation of the lining of the heart (only if left breast treated
- Cancer in the treated area caused by radiation

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

______________________________ Date:__________ Time:___________
Radiation Oncologist

______________________________ Date:__________ Time:___________
Patient or legally authorized representative

Interpreter responsible for explaining procedures and special treatment:

______________________________ Date:__________ Time___________
Interpreter

PATIENT UNABLE TO SIGN PRIOR TO PICTURE (☐) BECAUSE: _____

______________________________ Date:__________ Time____________
Physician

______________________________ Date:__________ Time____________
Witness