



**RADIATION ONCOLOGY DEPARTMENT
CONSENT FOR PERMANENT, INTERSTITIAL BRACHYTHERAPY TO THE PROSTATE**

PATIENT NAME: _____

MR#: _____

(Print name)

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 prostate with brachytherapy, or the insertion of permanent radioactive seeds, 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.

Brachytherapy is a type of treatment that involves placing a radioactive source directly in or next to a tumor or tumor bed. The brachytherapy treatment involves one visit to the operating room where the seeds are placed and I am sent home that day. I am aware an acute operative complication may arise, which might require prolonged hospitalization for such things as blood transfusion, antibiotic therapy or possible surgical intervention to deal with operative complication.

I understand that following the procedure there will be bleeding from the bladder immediately following the implant, as well as some bruising and tenderness in the perineum. This may require a catheter for a period of time. I also understand that I will experience urinary frequency, urgency and restrictive urinary outflow that will peak the first few days following the implant and then slowly decrease, but may increase again during the external beam phase of my treatment. These symptoms may take as long as 12 months to disappear completely or for me to feel at ease with.

I understand that there is a small risk that the permanently placed radioactive seeds may dislodge from the prostate and travel through the urethra out the penis when urinating or during ejaculation or travel through the veins to the lungs and permanently lodge there. This occurs in 1 to 5% of people and may potentially expose others to radiation if passed out of the body, or cause scarring of the lung or cancer of the lung. I will be given instructions regarding what steps I will take should a seed pass out of the body.

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.

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 PELVIS INCLUDING THE PROSTATE

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:

- Tiredness
- Anal soreness or itching

- Burning on urination
- Increased frequency of urination
- Urinary urgency
- Slowing of urinary stream
- Excess gas (flatus), cramping or diarrhea
- Skin reddening & soreness

Uncommon: occurring in 1-5% of people treated

- Skin blistering or peeling

Rare: occurring in less than 1% of people treated

- Severe diarrhea & dehydration
- Inability to urinate possibly requiring a tube to drain the urine

Long Term Reactions

Common:

- Impotence
- Tiredness persisting for months (especially if hormonal treatment is also given)

Uncommon: occurring in 1-5% of people treated

- Bowel spasms & diarrhea
- Rectal bleeding possibly requiring therapy
- Severe bladder irritation
- Urinary bleeding possibly requiring therapy

Rare: occurring in less than 1% of people treated

- Bowel complications requiring surgical procedure
- Rectal or urinary bleeding requiring transfusion or surgery
- Other tumors
- Cancer caused by radiation in the treated area
- Painful ulceration and infection in treated area

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

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

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 () BECAUSE: _____

Physician

Date: _____ Time: _____

Witness

Date: _____ Time: _____