

RADIATION ONCOLOGY DEPARTMENT

Consent for Y-90 Zevalin Radiation Therapy

PATIENT NAME: _____ MR#: _____

I hereby authorize Dr. _____ to perform the proposed Radiation Oncology Treatment of Y-90 Zevalin Radiation Therapy to my Whole Body.

I consent to have the Y-90 Zevalin 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 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 Y-90 Zevalin

Common:

- Low blood counts
- Tiredness
- Abdominal Pain
- Nausea

- Inflammation of nose/throat
- Diarrhea
- Cough
- Fever

Rare: occurring less than 1%

- Skin Blistering or peeling in the injection area

Long Term Reactions

- Prolonged low blood counts (uncommon)

- Rare: occurring less than 1 %
- Cancer caused by radiation
- painful ulceration and infection in the treated area

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

_____ 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: _____