The Royal College of Radiologists

Radiotherapy consent form for prostate cancer

This form should only be used if the patient is over 16 years old and has capacity to give consent. If the patient does not legally have capacity please use an appropriate alternative consent form from your hospital.

Patient details

Patient name:

Date of birth:

Patient unique identifier:

Name of hospital:

Responsible consultant oncologist or consultant therapeutic radiographer:

Special requirements: eg, transport, interpreter, assistance

Details of radiotherapy

Radiotherapy type:	**External beam radiotherapy**
Site: (Tick as appropriate)	☐ **Prostate/seminal vesicles** ☐ **Prostate bed** ☐ **Pelvic lymph nodes** ☐ **Other (please specify)**
Aim of treatment: (Tick as appropriate)	☐ **Curative** – to give you the best chance of being cured ☐ **Adjuvant** – treatment given after surgery to reduce the risk of cancer coming back ☐ **Disease control/palliative** – to improve your symptoms and/or help you live longer but not to cure your cancer

You may have questions before starting, during or after your radiotherapy.

Contact details are provided here for any further queries, concerns or if you would like to discuss your treatment further.

Patient name: _____ **Patient unique identifier:** _____

Possible early/short-term side-effects

Start during radiotherapy or shortly after completing radiotherapy and usually resolve within two to six months of finishing radiotherapy. Frequencies are approximate.

Expected 50%–100%	☐ **Tiredness** ☐ **Urinary frequency** (passing urine more often than normal), **urgency** (sudden urge to pass urine) and **slower flow** compared to normal
Common 10%–50%	☐ **Hair loss in the treatment area** ☐ **Bowel frequency** (opening your bowels more often than normal) and **urgency** (sudden urge to open your bowels) ☐ **Looser stools** with more mucous or wind compared to normal
Less common Less than 10%	☐ **Skin irritation and colour changes in treatment area** – redness in white skin tones and subtle darkness, yellow/purple/grey appearance in brown and black skin tones ☐ **Cystitis/pain when you urinate** – due to bladder inflammation ☐ **Rectal pain/discomfort** – due to rectal inflammation ☐ **A feeling of not completely emptying your bowels** ☐ **Bleeding from your bladder or bowel** – usually mild
Rare Less than 1%	☐ **Urinary retention** – not being able to pass urine which may result in needing a urinary catheter ☐ **Urinary incontinence including urine leaking**
Specific risks to you from your treatment	

☐ **I confirm** that I have had the above side-effects explained. **Patient initials** _____

Patient name: _____ **Patient unique identifier:** _____

Possible late or long-term side-effects

May happen many months or years after radiotherapy and may be permanent. Frequencies are approximate.

Expected
50%–100%

- ☐ **Infertility** – Radiotherapy will affect your fertility. Please let us know about your plans for having children and we can advise accordingly.

Common
10%–50%

- ☐ **Urinary daytime/night-time frequency** (passing urine more often than normal) and **urgency** (a sudden urge to pass urine)
- ☐ **Bowel urgency** (a sudden urge to open your bowels)
- ☐ **Looser stools** – with more mucous or wind compared to normal
- ☐ **Changes in ejaculate** – such as reduced amount, dry, altered consistency or blood stained
- ☐ **Loss of orgasm**
- ☐ **Change to penile length/appearance**
- ☐ **Inability to achieve an erection**

Less common
Less than 10%

- ☐ **Cystitis/pain when you urinate** – due to bladder inflammation
- ☐ **Incomplete emptying of your bladder or reduced bladder capacity**
- ☐ **Urinary stricture** (a narrowing in your water pipe which may require surgery)
- ☐ **Bowel frequency** (opening your bowels more often than normal)
- ☐ **Inflammation of the rectum** which may cause pain when opening your bowels. This may also affect your sex life if you receive anal sex.
- ☐ **Bleeding from your bladder or bowel**
- ☐ **Intermittent abdominal discomfort**

Rare
Less than 1%

- ☐ **Urinary incontinence including urine leaking (1%)**
- ☐ **Pelvis/hip bone thinning and/or fractures**
- ☐ **Bowel/bladder damage which may require surgery** – due to perforation (hole), fistula (abnormal connection between two parts of your body), bowel obstruction (blockage) or severe bleeding
- ☐ **An increased risk of a different cancer in the treatment area**
- ☐ **Radiotherapy to your pelvic lymph nodes:**

  Lymphoedema – fluid build up in your legs and potentially your scrotum

  Malabsorption – problems with nutrient absorption

  Neuropathy – damage to nerves which could cause pain, numbness or weakness in your legs.

Specific risks to you from your treatment

I confirm that I have had the above side-effects explained.

Patient initials _____

Patient name:

Patient unique identifier:

Statement of health professional

(to be filled in by health professional with appropriate knowledge of proposed procedure)

– I have discussed what the treatment is likely to involve, the intended aims and side-effects of this treatment.
– I have also discussed the benefits and risks of any available alternative treatments including no treatment.
– I have discussed any particular concerns of this patient.

Patient information leaflet provided: ☐ Yes / ☐ No – Details:

Copy of consent form accepted by patient: ☐ Yes / ☐ No

Signature:

Date:

Name:

Job title:

Statement of patient

– I have had the aims and possible side effects of treatment explained to me and the opportunity to discuss alternative treatment and I agree to the course of treatment described on this form.
– I understand that a guarantee cannot be given that a particular person will perform the radiotherapy. The person will, however, have appropriate expertise.
– I have been told about additional procedures which are necessary prior to treatment or may become necessary during my treatment. This may include permanent skin marks and photographs to help with treatment planning and identification.
– I agree that information collected during my treatment, including images and my health records may be used for education, audit and research. All information will be anonymised. I am aware I can withdraw consent at anytime.

Tick if relevant

☐ I understand that I should not conceive a child or donate sperm during the course of my treatment and I will discuss with my oncologist when it will be safe for me to conceive a child after radiotherapy.

☐ I understand that if I were to continue to smoke it could have a significant impact on the side-effects I experience and the efficacy of my treatment.

☐ I do not have a pacemaker and/or implantable cardioverter defibrillator (ICD).

or

☐ I have a pacemaker and/or implantable cardioverter defibrillator (ICD) and I have had the risks associated with this explained to me.

Signature:

Patient name:

Date:

Statement of:

☐ **interpreter**
☐ **witness** (where appropriate)

☐ I have interpreted the information contained in this form to the patient to the best of my ability and in a way in which I believe they can understand.

or

☐ I confirm that the patient is unable to sign but has indicated their consent.

Signature:

Name:

Date:

Patient confirmation of consent

(To be signed prior to the start of radiotherapy)

I confirm that I have no further questions and wish to go ahead with treatment.

Patient initials

Date:

