DISCLOSURE AND CONSENT FOR RADIATION THERAPY

As a patient, you have the right to be informed about your condition and the recommended radiation therapy procedure to used to treat your condition. This disclosure is not meant to alarm you; however, there are certain risks which are associated with radiation therapy. This explanation is intended to inform you of those risks so that you may give or withhold your consent to the recommended procedure on an informed basis. Please carefully review the following and if you choose to proceed with this treatment, sign this consent in the space below:

I (we) hereby voluntarily request and authorize Dr. _____ as my physician, and such associates, technicians and the health care providers as they may deem necessary to treat my condition which has been explained to me (us) as:

_____

_____

_____

I (we) understand that my condition may be treated with external beam radiation therapy alone, with internal radiation implant alone or with both or in planned combination with surgery and/or chemotherapy.

I (we) understand that the following radiation therapy procedure(s) are planned for me and I (we) consent to and authorize these procedure(s) (specify technique and site):

_____

_____

_____

I (we) further authorize the taking of photographs or placing of tattoo or skin marks necessary for treatment.

Photographing or Videotaping - Please initial "Yes" or "No":

____ Yes ____ No I consent to the photographing or videotaping of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, providing my identity is not revealed by descriptive texts accompanying the pictures.

ALL FEMALES MUST COMPLETE: I (we) understand that radiation can be harmful to the unborn child.

[ ] I am [ ] I could be [ ] I am not pregnant

I (we) understand that there may be side-effects or complications from radiation therapy, either during or shortly after the course of treatment ("early reactions"), or some time later ("late reactions"). Any of the side-effects or complications may be temporary or permanent.

These reactions may be worsened by chemotherapy or surgery before, during or after radiation therapy or by previous radiation therapy to the same area. Early and late reactions which could occur as a result of the procedure(s) are listed below. With few exceptions, these reactions affect only the areas actually receiving radiation therapy.

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(Place list(s) for specific region or regions of the body receiving radiation therapy here. A single form may be used for multiple regions or a separate form may be used for each separate region.)

_____

_____

_____

The nature and purpose of the proposed procedure, the alternative methods of treatment, and the risks and hazards if treatment is withheld have been explained to me (us) by my physician. I (we) have had an opportunity to discuss these matters with my physician and to ask questions about my condition, alternative methods of treatment and the proposed procedure(s). I (we) understand that no warranty or guarantee has been made to me (us) as to result or cure.

Patient/Other Legally Authorized Representative (signature required):

_____ _____

Print Name Signature

If Legally Authorized Representative, list relationship to Patient: _____

Date: _____ Time: _____ AM/PM

Witness:

_____ _____

Print Name Signature

_____

Address (Street or P.O. Box)

_____

City, State, Zip Code

Second Witness if Telephone Consent:

Print Name _____ **Signature** _____

Language Services Used ☐ **Yes** ☐ **No** **Language Provider Confirmation Number:** _____

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Physician Attestation
I have explained the Risks, Hazards and Benefits involved in the medical care, technical and/or surgical procedure(s) outlined on this consent form to the patient or the person authorized to give informed consent prior to their consent. If written materials explaining the Risks/Hazards/Benefits are required to be provided to the patient by the provider performing the medical care and/or surgical procedure, those have been provided.

Physician Signature: _____ Date: _____ Time:_____AM/PM_____

Consent and Disclosure Form Adopted from the Texas Administrative Code Figure: 25 TAC §601.4(a)(1).

PATIENT IDENTIFICATION