

INFORMED CONSENT

**RADIATION ONCOLOGY CENTER
OF SOUTHEASTERN PENNSYLVANIA
(ROCSP)**

1 Presidential Blvd., Suite 100
Bala Cynwyd, PA 19004
Ph: 610-667-3020. Fx: 610-6671817

NAME: _____

DOB: _____ Date: _____ Time: _____

____ I, _____ hereby agree to authorize
Dr./Drs. _____
and such associates and assistants as he/she may designate to perform upon me (or upon the above
named Participant) the following treatment or procedure including the use of immobilization
devices where appropriate and necessary:

Radiation Therapy to: _____

The purpose of treatment is to: _____

____ I acknowledge that other appropriate alternative treatments or procedures and their relative
advantages and disadvantages, have been fully discussed with me, including:

____ I have been informed of the nature and purpose of the procedure or treatment, the
risks and consequences involved, including the possibility of complications and/or death.

____ I acknowledge that no guarantee or assurance has been made as to the outcome
that may be obtained.

____ I understand that, because of the nature of the treatment course or procedures, there may be
short term and long term side effects and risks described, but not limited to those listed below and
I agree and accept such potential risks and side effects.

____ I was informed that all reasonable precautions are and will be taken to reduce risks during the
delivery of the treatment or procedure.

____ I understand that I am free, at any time, to withdraw my consent and stop the treatment or
procedure at my own risk.

____ I authorize ROCSP to keep, preserve, publish, use for education, research or dispose of the results
of the treatment or procedure described herein.

____ I authorized photographs to be taken of my face for identification. Also photos of those
parts of my body being treated. Also permit small tattoos on my skin used as reference points for
treatment purposes and permit such photographs to be used for medical education, knowledge, or
research. Such photographs will become the property of ROCSP.

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Radiation Oncology Center

NAME: _____ Date: _____

_____ IF FEMALE: I understand that radiation has damaging effects on unborn embryo/ fetuses.
I confirm that I am NOT pregnant and have no reason to believe that I am pregnant.
Reason: (optional) _____

_____ I also acknowledge that, in rare occasions, a malignant tumor may develop several years later in the **radiated area only** as a result of radiation exposure and chemotherapy given before, during or after radiation. Risk is higher in children and young adults

_____ I understand that the side effects and possible complications checked below may, to a lesser or greater degree, occur in association with, or as a consequence of the treatment or procedure.

Skin and Soft Tissue

- _____ Skin soreness, irritation, redness, peeling, itch, pigmentation
- _____ Hair loss which may be permanent
- _____ Swelling and/or pain of arm, leg, hand or foot
- _____ Skin ulceration, necrosis
- _____ Skin/soft tissue thickening

Breast/Lymph Nodes

- _____ Breast contracture (smaller) and/or thickening
- _____ Risk of ulceration, delayed healing
- _____ Dilated veins (telangiectasia)
- _____ Scar (fibrosis) on underlying lung
- _____ Asymmetric nipple secondary to scarring or necrosis
- _____ Risk of brachial plexus (nerves) injury causing arm pain, tingling, weakness
- _____ Risk chronic arm swelling (lymphedema) requiring treatment
- _____ Risk of weakening of ribs, prone to fracture
- _____ Risk of coronary/cardiac insufficiency, damage and/or infarct
- _____ Changes in nipple sensation

Central Nervous System, Eye and Orbit

- _____ Brain impairment: seizures, paralysis, loss of cognitive function, memory loss
- _____ Necrosis requiring surgery
- _____ Damage to cranial nerves (optic, trigeminal, facial, etc.) or peripheral nerves
- _____ Blindness
- _____ Cataracts
- _____ Corneal ulceration
- _____ Temporary or permanent dryness or excessive tearing
- _____ Spinal cord damage: paralysis, weakness, sensory changes
- _____ Other _____

Head and Neck

- _____ Soreness of mouth and/or throat (mucositis)
- _____ Difficulty swallowing (transient/permanent)
- _____ Loss or alteration of taste
- _____ Decrease quantity and thickening of saliva (transient/permanent)
- _____ Dryness of mouth (transient/permanent)
- _____ Tooth decay
- _____ Bone damage (osteoradionecrosis), may require surgery or Hyperbaric Oxygen Therapy (HBO)
- _____ Risk of vessel rupture due to tumor break down causing severe bleeding and/or death
- _____ Other: _____

FOR CARE THAT'S CENTERED ON YOU

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NAME _____ DATE _____

Chest

- Cough with increased sputum/phlegm production
- Damage to lung tissue with impaired breathing
- Fluid around the heart (pericarditis)
- Damage to coronary arteries with increased risk of heart attacks
- Damage to heart muscle and large vessels
- Difficulty swallowing , short or long term that may require dilatation or surgery
- Fistula may develop as the tumor breaks down with treatment (XRT/Chemo), may require surgery
- Pneumothorax requiring chest tube
- Other: _____

Abdomen and Pelvis

- Nausea and/or vomiting, diarrhea
- Liver damage (liver clots, focal fibrosis)
- Kidney damage
- Stomach and/or bowel damage with ulceration, perforation, bleeding and/or obstruction requiring surgery
- Fistula requiring surgery (colostomy, ileostomy)
- Bladder damage, bleeding that may require treatments: laser or Hyperbaric Oxygen Therapy (HBOT)
- Urinary frequency and/or burning on urination
- Rectal pressure and/or bleeding that may require laser treatment and/or HBOT
- Rectal or bowel ulceration/perforation which may require a colostomy or HBOT
- Temporary or permanent sterility
- Temporary or permanent impotence
- Other: _____

Endocrine & Blood

- Cessation or change in menstrual activity
- Decrease in thyroid or pituitary function requiring hormonal replacement
- Decrease in blood counts requiring transfusions

Other sites not listed above

I confirm that this Informed Consent Agreement for radiation procedures has been fully explained to me, and that I have carefully read and understand the Agreement.

DATE _____ SIGNED _____
Signature of patient (or parent / legal guardian if unable to sign)

Witness signature

Relationship, if not Participant

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NAME _____ DATE _____

State reason patient is unable to sign:

PHYSICIAN'S CERTIFICATION

I hereby certify that the patient, or a person authorized to act in his/her behalf has been fully informed in lay terms by me or by one of my physician's associates, of the nature of the Radiation Therapy either external or interstitial/intracavitary, the alternatives as to treatment and the consequences of and risks to the patient inherent or associated with the procedure and has authorized the performance of the procedure.

Physician signature

Date

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