Figure: 25 TAC §604.2(1)

DISCLOSURE AND CONSENT FOR RADIATION THERAPY

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended radiation therapy procedure to be used to treat your condition, and 3) the risks related to the radiation therapy procedure. This disclosure is designated to provide you this information, so that you can decide whether to consent to receive the recommended procedure. Please ask your physician/healthcare provider any remaining questions you have before signing this form.

Description of Radiation Therapy Procedure(s)

I voluntarily request my physician [name/credentials]

______________________________ and other health care providers to treat my condition which is:

____

____

____.

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

____

____

____.

I 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 agree to the taking of photographs or placing of tattoo or skin marks on me if necessary for treatment.

____.

Risks Related to Radiation Therapy Procedure(s)

Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the procedure(s) planned for me. The chances of these occurring may be different for each patient based on the procedure(s) and the patient's current health.

INITIAL ONE:

I understand that radiation can be harmful to the unborn child.

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

[___]**INITIAL IF APPLICABLE:**

I HAVE AN IMPLANTED ELECTRONIC DEVICE (such as a pacemaker, defibrillator or nerve stimulator). I understand radiation to the device can cause malfunction of the device.

I understand that the risks from radiation therapy may occur during or shortly after the course of treatment ("early reactions"), or sometime later ("late reactions"). The risks may be temporary or permanent.

These risks may be made worse if you have received chemotherapy or surgery before, during or after radiation therapy or if you had radiation therapy before to the same area. Risks or 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 of the body actually receiving the_radiation therapy.

Risks for this specific part of the body receiving radiation therapy, which are divided into early and late reactions, include, but are not limited to [**include List A risks here and additional risks if any]:**

____

____

____

Granting of Consent for Radiation Therapy Procedure(s)

By signing below, I consent to the radiation therapy procedure(s) described above. I acknowledge the following:

- I understand this procedure(s) does not guarantee a result of a cure to my condition.
- I have been given an opportunity to ask questions I may have about:
  1. Alternative forms of treatment,
  2. Risks of non-treatment,
  3. Steps that will occur during my procedure(s), and
  4. Risks and hazards involved in the procedure(s).
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

____

Patient/Other Legally Authorized Representative (signature required):

________________________________ ________________________________

Print Name Signature

If Legally Authorized Representative, list relationship to Patient:

____

Date: ________________________ Time: ______________________A.M./P.M.

Witness:

______________________________ ______________________________

Print Name Signature

Address (Street or P.O. Box)

City, State, Zip Code