UAB MEDICINE
UAB Hospital
Radiation Oncology

Keyplate

Radiation Oncology – Consent

Procedure(s)/Treatment: _____

Consent: I authorize and direct Dr. _____and/or his/her associates to perform the above named radiation treatment. My physician has explained the reasons and need for radiation therapy. I have reviewed my clinical condition with my physician including the anticipated benefit to be obtained from radiation therapy, the risks of radiation therapy, and any alternatives that may exist should treatment be declined. My physician has explained the exact mode and type of radiation that will be administered. While no guarantee has been made to the results of any planned treatment, I understand that it is, in the best judgment of my physician, to my benefit. I also understand that physicians in training (residents), healthcare industry representative (vendor), and/or other qualified personnel may participate in this procedure, under the supervision of my physician, at a level of involvement deemed appropriate by my Attending Physician.

Medications & Procedures: I further understand that any procedures, administration of medications including anesthetics, include certain risks. I understand that I may discontinue treatment at anytime and it will not prejudice my continuing care or relationship with the staff of this department.

Reproductive: I understand with persons of reproductive age that radiation in some incidences can have an effect upon the reproductive organs. I have discussed my clinical condition with my physician, and he/she has answered by questions. I realize that pregnancy may be contraindicated during radiation therapy. I understand the risk to myself and my unborn child should I become pregnant during treatment, and I have been advised to practice birth control in order to prevent pregnancy.

Additional Services: In the course of the above treatment, certain conditions may arise that may require additional services including but not limited to surgical procedures, administration of anesthesia, administration of medication, and radiology services. I request that my physician, in his or her best judgment, direct any further therapeutic means to improve my condition.

Scientific and Educational Purposes: I do hereby authorize and direct my physician or the pathologist to examine, retain for scientific and/or educational purposes, or dispose of all such tissues, organs, or bodily fluids that shall be removed by operation or biopsy performed upon me. I understand that my identity will be concealed and my privacy maintained.

Consent Videotape/Photograph: I consent to photography of my face and/or those regions of my body that need to receive radiation therapy as required for identification purposes, documentation of my medical condition, and/or purposes of medical education. I further understand that my identity will be concealed and my privacy maintained if the material is used for educational purposes.

Advance Directives: I understand advance directives are not honored in the outpatient setting except as agreed to by physician and patient.

Sharp Instruments: I understand this procedure will require the use of sharp instruments. Therefore, in the event that a member of the clinical staff punctures his/her skin, I give consent to staff to perform all necessary serologic testing for the HIV antibody, any other blood borne infections, and disclose to appropriate personnel and as may be otherwise required by state or federal law.

I have discussed the procedure named above, including its material risks, and benefits, including potential problems related to recuperation, and side effects related to alternatives including the possible results of not receiving care, treatment, and services based on the available clinical evidence as determined by the responsible practitioner's clinical judgment. The patient/family understands and acknowledges that questions were answered to their satisfaction and requests to proceed.

_____
Patient's Signature Time Date

IF THE PATIENT IS A MINOR or UNABLE TO SIGN, COMPLETE THE FOLLOWING **(print all information in this section):**

Name (Print):_____ Address: _____

Relationship: _____ Patient cannot sign because: _____

Father and/or Mother	Time	Date	Guardian/ Other Person	Time	Date
Physician/Dentist/Practitioner Signature	Time	Date	Witness	Time	Date
			Witness	Time	Date

Translation (if necessary) – The foregoing document has been accurately and completely translated, with assistance by an approved translator or approved translation service, to the signatory identified above in the patient's/patient representative's preferred language. The patient/patient representative indicated their understanding of all terms and conditions and acknowledged his/her agreement by signing this document in my presence.	Preferred Language If Not English:
	Translators Name/ID#