Space for Medical Institution Name and Logo

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טופס הסכמה לטיפול קרינתי
CONSENT FORM: RADIOTHERAPY

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____ _____
Last Name First Name
concerning my malignant disease and its treatment, including a recommendation for radiotherapy (henceforth: "the treatment").

I have been given an explanation that the purpose of the treatment is to damage and destroy the tumor cells. Radiotherapy is used for treating the disease or preventing recurrence. I have been given an explanation that radiotherapy may harm any organ in the radiation field. The radiotherapy is carefully planned in an attempt to reduce, diminish or prevent possible damage to healthy organs included in the radiation field. Treatment planning includes simulations and additional imaging techniques, such as CT and MRI and intravenous injection of contrast medium, as required, and therefore, I must **notify the attending physician and radiologist of any intolerance of iodine that I may have, prior to performance of a test requiring the injection of contrast medium.** Treatment planning also includes marking of the radiation field on the skin, using a tattoo or other markings that may by permanent. Anesthesia or sedation may be necessary, and pictures may be taken for patient identification and to document the radiation field. Treatment duration will be determined by a pre-defined plan, or according to the patient's reaction. I have been told that several side effects of radiotherapy are currently known and that some may occur months and years after treatment administration:

1. The radiation may cause anything from redness, a burning sensation and itching to ulceration of the radiated area. At a later stage, thickening of the skin and scarring, dilatation of blood vessels, changes in skin color and chronic ulcers may occur.
2. Radiation causes loss of hair in the radiated field, which may be temporary or permanent.
3. Loss of appetite, nausea and vomiting, accompanied by weakness and loss of weight, may occur. These side effects are usually reversible.
4. In rare case, the red blood cells, white blood cells and/or platelets may be damaged, and their number temporarily reduced. A decrease in the number of red blood cells can be treated with transfusion of blood units or medicinal means. A decrease in the number of white blood cells may reduce the body's resistance and lead to infections. A fever may be a manifestation of an infection. **I am well aware that I must immediately notify the attending staff or refer to the emergency room in any case of a fever of 38 degrees or higher.** Any indication of infection will, in most cases, require antibiotic treatment at home or in the hospital. Medications are sometimes used to increase the number of white blood cells. A decrease in the number of platelets may, in extreme cases, cause bleeding that can manifest in various ways, including the appearance of red urine, or various speckles and spots on the skin. **Any hemorrhage requires immediate referral for treatment**.
5. In pregnant women, radiation may harm the fetus.
6. In addition, it was made clear that:
    A. Depending on the radiated area, there may be additional special side effects that were not mentioned above, such as: lung damage, stomach damage, intestinal

damage, kidney damage, liver damage, damage to the spine, urinary bladder damage, rectal damage, nerve damage, and impairment of fertility. **In children** – there may be delayed growth and development. I have been told that I will receive more detailed information according to the radiated area.

If a joint or joints are included in the radiation field, damage may be caused leading to stiffness of the joints, pain and inflammation that will limit motion.

B. If a bone or bones are included in the radiation field, damage may be caused leading to fractures.
C. There is a rare possibility of the occurrence of a secondary malignancy as a result of the radiotherapy.
D. Treatment of the side effects may necessitate hospitalization.
E. In rare cases, the side effects may be particularly severe, and even end in death.

I hereby give my consent to perform the treatment.

I know and agree that the treatment and any other procedure will be performed by any designated physician, according to the institute's procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institutional standard degree of responsibility and in accordance with the law.

_____	_____	_____
Date	Time	Patient Signature

_____	_____
Name of Guardian (Relationship)	Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

_____	_____	_____
Name of Physician	Physician Signature	License No.

* Cross out irrelevant option.