Gleneagles Hospital
HONG KONG
港怡醫院

Consent for Brachytherapy Procedure and Treatment

For Clinic Use	For RTO Use
Please fill in or affix patient label	*Please fill in or affix patient label*
Name : M / F	Name : M / F
HKID No. : DOB :	HKID No. : DOB :
Contact No. :	Contact No. :

RADIOTHERAPY AND ONCOLOGY CENTRE

A. Person(s) Signing This Form (The Signatory)

The Patient is named in the right hand top corner of this Form.

The signatory signing this Form is/are: (Please tick "✓" as appropriate.)

- ❑ the patient.
- ❑ the parent or guardian of the patient who is a minor (age under 18).
- ❑ the patient's legal guardian appointed under Mental Health Ordinance (MHO) with power to consent to the proposed procedure / treatment.

Details of the ❑ parent / ❑ guardian / ❑ legal guardian appointed under MHO

_____ _____

Full Name(s)of Parent or Guardian ❑ HKID Card / ❑ Identity Document No of Parent or Guardian

B. Explanation of The Nature and Effect / Benefits Of The Procedure / Treatment

The doctor, who signs this Form, has explained the nature and effect / benefits of the procedure / treatment to the Patient and/or Patient's parent or guardian/ the Patient's legal guardian appointed under MHO as set out below:

1. The Patient's diagnosis / indications for the procedure / treatment:

   _____

2. Name and nature of the procedure / treatment for the Patient:
   - ❑ Brachytherapy (need surgical/general anaesthetic/spinal anaesthetic procedures [REQUIRING ANAESTHETIST])
   - ❑ Brachytherapy (need local anaesthetic procedures [NOT REQUIRING ANAESTHETIST])
   - ❑ Brachytherapy (not requiring anaesthetic procedures)
3. Brachytherapy Site / Sites: _____
4. The intended effect / benefits of the procedure / treatment for the Patient:
   ❑ Radical Treatment / ❑ Adjuvant Treatment / ❑ Palliative Treatment

C. The Risks and Complications / Side Effect Associated With The Procedure / Treatment

_____

- ❑ Refer to information sheet :_____
- ❑ Second course radiotherapy / Re-irradiation consent (same site as per item B.3 above)
- ❑ Effects / risks associated with the procedure / treatment to the Cardiovascular Implantable Electronic Devices. (Refer to Information Sheet:_____)

D. The Risks / Complications For The Option Of No Treatment

Cannot obtain the intended effect / benefits (as per item B above) if no treatment is opted.

E. Any Consequential Procedure(s) Which May Become Necessary During / Following The Procedure / Treatment (If applicable) : _____

F. Any Additional Treatment That Requires Prior Consent From The Patient Before Proceeding The Procedure (If applicable) : _____

G. Information Sheet (Please tick "✓" if applicable)

- ❑ I / We confirm that I / we have been provided with an information sheet on the procedure / treatment (copy attached), that I / we have reviewed and fully understand the contents.

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H. Consent to The Procedure / Treatment

I / We, the undersigned Patient and /or Patient's parent or guardian/Patient's legal guardian appointed under the MHO:

1. consent to undergo / consent to the Patient undergoing the procedure / treatment set out above. The doctor (who signs this Form) has fully explained the nature, effects, benefits, general / specific risks and complications / side effect of procedure / treatment, to me / us which I / we fully understand.
2. understand other treatment options and their associated outcomes and risks. The doctor (who signs this Form) has answered any questions and enquiries raised by me / us which I / we fully understand.
3. consent to undergo / consent to the Patient undergoing such alternative or further procedures / treatment that the doctor(s) / health professional(s) may consider necessary or desirable.
4. understand that although the doctor(s) / health professional(s) will perform the procedure / treatment in the Patient's best interest, there is no guarantee of cure or improvement. Fully aware that the radiotherapy treatment is only delivered to targeted area, chances of disease progression, metastasis and/or recurrence may occur during or after the treatment.
5. understand the possible outcomes of **NOT** having the procedure / treatment. Aware that the procedure / treatment may be terminated as a result of disease progress or physical conditions of the undersigned Patient.
6. consent to undergo / consent to the Patient undergoing such tests and examinations that the doctor(s) / health professional(s) may consider necessary or desirable.
7. consent to / consent to the Patient authorize health professional(s) to take photographs of the treatment area for documentation. Understand the photographs or video recording may be taken for medical record keeping / teaching or research purpose.
8. understand that no assurance can be given by the hospital that the procedure / treatment, will be performed by particular doctor(s) / health professional(s). The doctors(s) / radiation therapist(s) who will perform the procedure / treatment will, however, be suitably qualified.
9. understand the described / said complications and risks of the procedure / treatment are not exhaustive. Rare complications may not be listed.
10. fully informed of the charges on such procedure / treatment and that extra fees shall be incurred if additional procedure / treatment considered necessary or desirable.
11. **For female patient only**: **I/We hereby confirm that I/the Patient undergoing the procedure/treatment am/is not pregnant and shall be responsible for all consequence should I/the Patient be found pregnant at the time of procedure/treatment.**
12. agree that this consent shall remain valid for 180 days from the date it was signed or the duration of one hospital admission even though the above procedure / treatment may be re-scheduled from time to time.
13. understand that, if I /we have any further questions, I / we can ask the doctor / health professional(s); and I /we have the right to withdraw my /our consent at any time after I / we have signed this form.

Signature(s) of Signatory(s)	Signature of Doctor	Signature of Witness (if applicable)
Full Name(s) of Signatory(s)	Full Name of Doctor	Full Name of Witness (if applicable)
Date	Date	Date (if applicable)

<u>This Part To Be Completed By Interpreter</u> *(Please fill in the below information if applicable)*

I _____ , _____certify that I have truly, distinctly and audibly
Full Name of Interpreter *HKID Card / Identity Document No.*

interpreted the consent of this document into _____ to the signatory.
Language / Dialect Used

Signature of Interpreter : _____ Date: _____

<u>Note</u>: The witness, if available, should be involved in the whole process, from explanation to signing of this Form.