

Informed Consent - ¹³¹I Cancer Therapy

Patient Name: _____ Date: _____

This is a patient consent form for a routine nuclear medicine therapeutic procedure: **Iodine-131 Therapy for Patients with Cancer of the Thyroid**, by doctors or hospital; workers at this facility.

1. I _____ know that I will be treated with radioactive Iodine-131 by a nuclear medicine physician and nuclear medicine technical staff. Before this treatment, I should have as little to eat as possible for at least four (4) hours, preferably since midnight. The treatment itself involves swallowing either liquid (through a straw) or capsules of radioactive Iodine-131. Prior to the treatment, I will be given precautions regarding my behavior around others, specifically children and pregnant individuals due to the minimal radiation hazard I would present. Additionally, I have been requested not to eat for at least one (1) hour after the therapy, if possible.
2. I know that Iodine-131 might harm my child if I am pregnant or breastfeeding. I have told my doctors that I am **not pregnant** and have **stopped breastfeeding**.
3. I know that the **possible side effects** of my treatment that an average patient in my position would want to know before deciding whether to give consent are possible **slight nausea, swelling in the neck region** and **tenderness in your salivary glands**. My doctors have explained these side effects to me and all my questions about them have been answered.
4. I know that the **possible future health risks** from this treatment that an average patient in my position would want to know before deciding to give consent are the development of **hypothyroidism** (underactive thyroid gland) and a **minimal increased risk of cancer induction due to radiation**. Additionally, if cancer of the thyroid extensively involves my lungs, I have been told that, as a result of this therapeutic procedure, **pulmonary fibrosis, pulmonary edema** or **radiation pneumonitis** are possible future health risks to me. My doctors have explained these possible future health risks to me and all my questions about them have been answered.
5. My doctors told me about **other treatments** that might be right for me instead of Iodine-131 therapy alone. It is **surgical removal of tissue** involved with cancer of the thyroid followed by Iodine-131 therapy. My doctors have explained this to me and all my questions about it and about why this procedure is best for me have been answered.
6. I know that medicine is not an exact or perfect science. I can say that my doctors or anyone else at this facility have made no guarantees about my cure or about not having side effects or future health risks from Iodine-131 therapy.

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7. I know that I can withdraw my consent at any time I want to for any reason **before the treatment starts**, even though I have signed this consent form. If I do change my mind and withdraw my consent, I will still receive the same quality care from my doctors and from this facility that I would have given even if I didn't change my mind.

8. My doctors have talked to me about this procedure and all my questions about it have been answered. I have read this consent form and understand everything on it. I have decided to consent to Iodine-131 therapy for cancer of the thyroid.

9. I understand that I am entitled to and will receive a signed copy of this form, if I wish.

I have read this INFORMED CONSENT TO ROUTINE NUCLEAR MEDICINE THERAPEUTIC PROCEDURE form. It has been fully explained to me and I certify that I understand its contents. I have decided to consent to Iodine-131 therapy for cancer of the thyroid.

Date _____

Time _____

PATIENT SIGNATURE

WITNESS SIGNATURE

Patient may sign with an "X" if physical
Condition or illiteracy prevents full signature.
Two (2) witnesses are then required.

WITNESS SIGNATURE

Patient is under 18 years of age or incompetent

PARENT / GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT