

# Informed Consent - <sup>131</sup>I Hyperthyroid Therapy



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

This is a patient consent form for a routine nuclear medicine therapeutic procedure: **Iodine-131 Therapy for Patients with Hyperthyroidism (Overactive Thyroid Gland)**, 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 **slight tenderness in your salivary glands**. These side effects have been explained to me and my doctors, 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). 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 part of my thyroid gland** or **treatment with medications**. My doctors have explained them to me and all my questions about them 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 has made no guarantees about my cure, or about not having side effects or future health risks from Iodine-131 therapy.
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.

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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 hyperthyroidism.

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 hyperthyroidism.

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