PATIENT'S CONSENT TO RECEIVE RADIATION THERAPY

Patient Name: ____ DOB: __________________

Treatment Site: ____

I hereby consent to the administration of radiation therapy treatments as may be deemed advisable by **Lanceford Chong, MD** or his designated associate physician. Treatment may be delivered in the form of x-rays, electrons, gamma rays, or other radioactive materials or some combination of these methods.

Radiation therapy can have **SIDE EFFECTS.** Common are redness or tanning of the skin and/or loss of hair over the areas treated. Fatigue and nausea may also be experienced. **Depending upon the region being irradiated,** more serious and persistent effects upon the body may result that could impair the function of an organ or could require surgical or non-surgical medical treatment. I understand that radiation therapy can cause cancers on its own, but that the benefits of treatment outweigh this risk. I agree to assume the risk of such reactions and effects as these have been fully explained to me to my satisfaction.

I recognize that **Lanceford Chong, MD** or his designated associates are licensed physicians and assistants and nurses are competent in the field of radiation therapy and as such, are qualified to administer the necessary treatment.

A facial photograph and photographs of the treatment fields will be necessary for identification and documentation; in addition, from time to time it may be necessary to document clinical response to treatment with photographs and I hereby give my permission to have the necessary photographs performed and kept in the clinic records.

Patient Signature	Date
Guardian Signature	Date
Physician Signature	Date

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