Taichung Armed Forces General Hospital
Radiation Therapy
Consent Form
放射治療同意書

* Basic Information

Patient Name:_____ID No.:_____Medical Record No.: _____

Date of birth:_____YYYY_____MM_____DD Sex:_____ Bed No.:_____

I. Therapy planned (Provide the Chinese name. The medical term in foreign language may be indicated to the Chinese name if necessary)

1. Disease name:
2. Name of therapy recommended:
3. Reason for therapy recommended:

II. Physician statement

1. I have explained the therapy to the patient in ways as comprehensible as possible to provide the patient with the relevant information, particularly the following:
   - □ Reason why the therapy must be performed, steps and site of the therapy, and risks of the therapy.
   - □ Therapy complications and possible management methods.
   - □ Potential consequences if this therapy is not performed and alternatives to this therapy.
   - □ Possible temporary or permanent symptoms expected after the therapy.
   - □ I have given the patient any other information available related to the therapy.
2. I have provided the patient with adequate time to ask the following questions about the therapy and I have answered the questions:
   - (1) ---
   - (2) ---
   - (3) ---

Signature/seal of responsible doctor:_____ Date: YYYY MM DD

Time: hh mm

III. Patient statement

1. The physician has explained to me and I have understood the information relate to the necessity, steps, and risks of the therapy.
2. The doctor has explained to me and I have understood the risks associated with alternative therapies that I may choose.
3. The doctor has explained to me and I have understood the possible prognosis of the therapy and risks if the radiotherapy is not performed.
4. Regarding my condition, and the progress and methods of the therapy, I have already raised my questions and concerns with the doctor and have received responses.

5. I understand that this therapy is currently the most appropriate option, but it carries certain risks and there is no guarantee that it will significantly improve my condition.
6. I understand that the hospital will use the contact information provided in this consent form to reach out to me based on medical needs.

Based on the above statement, I hereby give my consent to this therapy.

Consenter Signature: Relationship to patient:

ID No./Permanent Residence or Passport No. Address:
Telephone:
Date: YYYY MM DD Time: hh mm

Notes:

I. If the consenter is not the patient, the relationship to the patient should be indicated in the “Relationship to patient” field.

II. The consent form should be signed by the patient personally, except in the following cases:

1. If the patient is a minor or unable to express consent for any reason, the form may be signed by a legal guardian, spouse, relative, or someone with a close relationship.
2. A "close relationship" to the patient refers to someone with a particularly close relationship, such as a partner (regardless of gender), cohabitant, close friend, etc.; or someone who, by law or contract, has a duty to protect the patient, such as a guardian, juvenile protection officer, school teacher or staff member, at-fault driver, or military/police/fire officer.
3. If the patient is illiterate, a thumbprint may be used in place of a signature, but two witnesses must sign next to the thumbprint.