**Patient Consent for RADIOACTIVE IODINE TREATMENT**

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CHI Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activity (±10%) of 131I to be administered**:

\_\_\_\_\_\_\_\_\_\_\_\_MBq

**Changes in drug therapy prior to administration of radioiodine (discussed with patient)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Statement of Doctor prescribing treatment**

COVID vaccine status: Fully vaccinated Partially vaccinated Not vaccinated

Is the patient at high risk of severe COVID? No Yes

Does the patient need to ‘self-isolate’ prior to treatment? No Yes

* I have discussed the patient’s treatment with him / her.
* I have considered other medical conditions (in particular incontinence and pregnancy) which may affect treatment. The following medical condition(s) require risk assessment:
* I have considered non-medical factors (such as household members and employment) which may affect treatment. The following non-medical factors require risk assessment:
* I have checked that the patient has not had IV contrast imaging in the last 8 weeks.
* I have checked that the patient is not currently taking amiodarone and/or has not taken it within the previous 12 months
* I have supplied a copy of the appropriate ‘Information for Patients’ and, where relevant, the ‘Information for Carers’ and I have discussed the precautions he / she should take to minimise the radiation exposure of other people (in particular the requirement to avoid contact with children and pregnant women and to take time off work).
* For individuals who require to self isolate, I have supplied a copy of the ‘Self Isolating Guidance’ and confirmed with the patient that they will be able to comply.
* I have informed the patient that they can withdraw their consent for treatment at any time.

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dept: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement of patient or person with responsibility for patient**

* I have read and understood the Information for Patients, in particular I understand the precautions I must take to minimise the radiation exposure of other people.
* I give my consent to receive radioactive iodine treatment.

*For individuals who require to self-isolate:*

* I have read and understood the ‘Self-Isolating Guidance’, I understand the precautions I must take to minimise the risk of contracting COVID-19 before treatment.

*For women of reproductive age:*

* I confirm that I am not pregnant and that I will tell the hospital staff if I become pregnant before I receive the radioactive iodine treatment.
* I understand that I should not receive radioactive iodine treatment when I am pregnant and I should avoid pregnancy for at least 6 months after receiving the radioactive iodine treatment.

*For men:*

* I understand that I should avoid fathering a child for at least 4 months after receiving the radioactive iodine treatment.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has a copy of this consent been taken by patient? Yes / No (please circle)**