Coastal NeuroSurgery P.A.

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STEREOTACTIC RADIOSURGERY BY CYBERKNIFE™ CONSENT FORM

Patient:

You have been scheduled for stereotactic radiosurgery by Cyberknife, ™ . Your treatment is scheduled for _____. The treatment is performed in the Radiation Oncology Department at Community Medical Center. The treatment involves placing a plastic mask over your face and head and securing it to a table. After you are placed in the frame, a CAT scan of the brain is obtained. After the CAT scan is completed you will go home while stereotactic planning takes place to determine how to best treat the tumor with minimal exposure of the normal brain tissue to the radiation. After the planning is completed you will return to the radiation oncology department to complete the treatment. You will be placed on the treatment table with your head secured to the table with the same mask as used during the CAT Scan and you will receive your radiation treatment. After the treatment is completed you will go home.

As with any surgery, there are risks that may occur during the surgery and in the postoperative period, including but not limited to:

1. Lack of benefit of the radiosurgery with persistent or worsening of symptoms.
2. Loss of a patch of hair in the area where radiation beam enters the scalp.
3. Irritation of scalp in the area where radiation beam enters.
4. Possibility of seizures, which may require medical treatment.
5. Injury to normal brain tissue resulting in neurologic deficits, although every effort is made to protect normal brain tissue from the effects of the radiation.
6. Possibility of developing radiation necrosis with brain swelling, which may require treatment with steroids and possibly surgery.
7. Any adverse reaction to medications given during the procedure.

I acknowledge that I have read the above consent form and all options and alternative treatments were discussed with me by Dr. Hartwell. In addition all of the above risks were discussed with me in detail, in laymen's terms, by Dr. Hartwell and I understand all the above risks and possible complications and wish to proceed with surgery.

Signed: _____ Date: _____