



STEREOTACTIC RADIOSURGERY CONSENT FORM

Patient:

You have been scheduled for stereotactic radiosurgery. Your surgery is scheduled for _____. The surgery is performed in the radiation oncology department under a local anesthetic. The surgery involves placing a stereotactic frame over your head and securing it to your skull with four screws. After you are placed in the frame, a CAT scan of the brain is obtained with contrast. After the CAT scan is completed you will return to your room 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 and you will receive your radiation treatment. After the treatment is completed the stereotactic frame will be removed and you will return to your room.

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

1. Infection of pinhole sites
2. Persistent pain at the pinhole sites.
3. Lack of benefit of the radiosurgery with persistent or worsening of symptoms.
4. Loss of a patch of hair in the area where radiation beam enters the scalp.
5. Irritation of scalp in the area where radiation beam enters.
6. Possibility of seizures, which may require medical treatment.
7. 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.

8. Possibility of developing radiation necrosis with brain swelling, which may require treatment with steroids and possibly surgery.
9. Any adverse reaction to medications given during the procedure.
10. Heart attack, stroke, coma and death.

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

1. No aspirin, Plavix, Coumadin or anti-inflammatory medication one week prior to surgery.
2. Nothing to eat or drink after 12:01 a.m. on _____.
3. Take the following medicines on the day of surgery with a small sip of water.

Patient: _____

Date: _____