	Affix Patient Label	
	Patient Name:	Date of Birth:

**Informed Consent
For Endoscopic Bronchial Ultrasound with Possible Fine Needle Aspiration**

This information is given to you so that you can make an informed decision about having **an Endoscopic Bronchial Ultrasound with possible Fine Needle Aspiration**.

Endobronchial ultrasound (EBUS) is used to provide images of your airway and lungs. It allows the doctor to see hard to reach areas and take biopsies.

For this test a tube is placed in your airway and lungs. Ultrasound is used to create images and guide needle placement for biopsies. Tissue samples might be taken from a lung mass and lymph nodes. The samples can be used to diagnose lung cancer, find infections, and identify other lung diseases. A pathologist is onsite to examine the samples. If more samples are needed they can be taken right away.

Reason and Purpose of the Procedure:

This test is used to assist your doctor in diagnosing and treating your problem.

Benefits of this procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.


- A diagnosis of your symptoms.

Risks of procedures:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of this procedure:

- **Bleeding.** This may need further treatment or repair.
- **Injury to your teeth, lips, or throat.** This is rare.
- **Infections that may require antibiotics.**
- **Reaction to the anesthetic may occur:** The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

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Risks associated with smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

Alternative Treatments:

- Do nothing. You can decide not to have the procedure.

If you choose not to have this treatment:

- We may be unable to diagnose your problem.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.



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By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
 - I understand its contents.
 - I have had time to speak with the doctor. My questions have been answered.
 - I want to have this procedure: **Endoscopic Bronchial Ultrasound with possible Fine Needle Aspiration:**
-
- I understand that my doctor may ask a partner to do the surgery.
 - I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to procedure. If so, please obtain consent for blood/products.

Patient Signature _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____ Date _____ Time _____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

Or

____ Patient elects not to proceed: _____ (patient signature)

Validated/Witness: _____ Date: _____ Time: _____