



Affix Patient Label

Patient Name: _____

Date of Birth: _____

Informed Consent

Biopsy Needle Consent

This information is given to you so that you can make an informed decision about having a _____

Guided Needle Biopsy of _____

Biopsy location: _____

The radiologist will use ultrasound, computed tomography (CT Scan), or other radiology imaging to guide placement of a biopsy needle and select the best location to biopsy. Small samples of tissue will be removed. These will be sent to the pathologist to examine. A final diagnosis will not be made at the time of the biopsy. The final result will be sent to your doctor, usually within a few days.

Local anesthetic will be injected at the biopsy site and you will be given some intravenous relaxing medication and pain medicine during the procedure. For most patients, the procedure is well tolerated and nearly painless. Some patients will have moderate discomfort during the biopsy.

Reason and Purpose of the Procedure

Determine if the abnormality is benign or malignant and try to make a specific diagnosis.

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.

- Help your doctor decide how to treat you
- Make a diagnosis
- Avoid unnecessary treatment

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 Procedures

- **Bleeding:** This could require admission to the hospital or a blood transfusion. In rare cases, an emergency operation or arteriogram is needed to stop bleeding.
- **Infection:** This could occur in the skin, soft tissue under the skin or at the internal biopsy site. These infections are rare. Antibiotic treatment might be needed.
- **Complications from sedation medicine:** You may have low blood pressure. You may have breathing problems including slow breathing and choking on vomit (aspiration). If you are sedated you will be monitored by a nurse and given oxygen to breathe.
- **Inconclusive results:** The results of the biopsy may not be definite. You may need another biopsy.

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Risks Specific to You:

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.

Alternative Treatments

Other choice:

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

If You Choose Not to Have this Treatment

- Your doctor may find it more difficult to treat your pain.

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.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- The biopsy tissue will be tested. It could be kept for research or teaching. I agree the hospital may discard the tissues in a proper way.
- Radiology images will be obtained. They will be part of my medical record. These may be published for teaching purposes. My identity will be protected.

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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 **Needle Biopsy of** _____
- I understand that my doctor may ask a partner to do the surgery/procedure.
- 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 surgery. IF so, please obtain consent for blood/product.

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

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.

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: _____ Date: _____ Time: _____

(patient signature)

Validated/Witness: _____ Date: _____ Time: _____