ENVISION
MEDICAL IMAGING

INFORMATION & CONSENT FORM

CT PROSTATE BIOPSY

Introduction

Your doctor has requested that you undergo a Prostate Biopsy under CT which is an interventional procedure.

Please read and sign this form so that we can be sure you understand the risks and complications potentially associated with this procedure. Please inform the booking staff if you are on Warfarin, Plavix, or any other blood thinning agents, or have any other medication allergies.

Procedure

The doctor will use CT guidance to determine the location of your prostate. He/she will then insert a thin tube, called the needle guide. The doctor will connect the needle guide to a biopsy apparatus.

It may be necessary to make more than one pass of the needle to achieve the proper location and ensure an adequate sample is taken for testing.

Risks and side effects

Complications are rare during this procedure, however, you should be informed of the possible risks and side effects.

Risks associated with this procedure include:

After the biopsy you may have blood in your stools (± 1 to 2 days), urine (± 4 days) or semen (± 30 days).

If you suffer from **severe blood loss** or **fever** (temp. above 38.5°C) then you should **immediately contact** your urologist or emergency centre, as this may indicate your prostate is inflamed or infected. In this case, you should tell your doctor that you have had a prostate biopsy.

The sample collected may have non-diagnostic material which may require further investigations.

Any medical procedure can potentially be associated with unpredictable risks.

Please ask questions about anything on this form that you do not understand.

I have read the information provided regarding my procedure. I understand the information and have had the opportunity to ask questions about what is going to happen, the reasons for the procedure being performed, and the associated risks. I agree to have the procedure performed.

Patient Name		
Patient Signature		Date
Signature of MIT / Radiologist		

OFFICE USE ONLY

ANTICOAGULANTS ☐ Yes ☐ No DIABETIC ☐ Yes ☐ No ALLERGIES ☐ Yes ☐ No DRIVER ☐ Yes ☐ No

PATIENT ID CHECKLIST

NAME confirmed ☐ DOB confirmed ☐ GENDER confirmed ☐ ADDRESS confirmed ☐

PROCEDURE CHECKLIST

TYPE confirmed ☐ SIDE confirmed ☐ CONSENT confirmed ☐ TIME OUT ☐