ENVISION
MEDICAL IMAGING

INFORMATION & CONSENT FORM

FINE NEEDLE BIOPSY

Introduction

Your doctor has requested that you undergo a Fine Needle Biopsy of

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which is an interventional procedure. This will be a fine needle biopsy, or a core biopsy, and will not infrequently require both.

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

An interventional radiology procedure involves the placement of a fine needle through the skin and into a designated location to obtain samples for pathology testing. The skin will be washed with antiseptic and a local anaesthetic may be injected. A fine needle is inserted, guided into position using ultrasound or CT and a biopsy taken. 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. The needle is removed and compression will be applied to the needle insertion site.

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:

- Pain or discomfort at the needle insertion site, bruising after the procedure, bleeding at the site, injury to a blood vessel *(which may require a blood transfusion)*, organ puncture, or infection.
- Inflammation which may involve redness or swelling and increased pain after 48 hours.
- 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 *(or signature of legal guardian)*		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 ☐