



**Consent For Trans Rectal Ultrasound And
Prostate Biopsy**

I understand I have been scheduled for needle biopsy of the prostate. This is to be done with a needle placed through the rectal wall into the suspicious areas of the prostate to see if cancer of the prostate exists. Most often the needle will be guided by an ultrasound probe, but on occasion, a finger guided biopsy will be done.

I have been informed that with the biopsy, possible risks and complications exists and may occur during or after the procedure. These include loss of blood, infection, burning with urination, urinary retention which may require catheterization. I acknowledge that no warranty or guarantee has been made to me as the results of my procedure or cure of my condition.

I acknowledge that tissues removed during this procedure may be disposed of by the hospital or physician in accordance with accustomed practice.

I certify that my physician as listed above has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, and recognized serious possible risks, complications and the anticipated benefits involved in the proposed treatment and the alternative forms of treatment, including non-treatment.

I understand that any aspect of this consent form that I do not understand can be explained to me in further detail by asking my physician.

I certify that this form has been explained to me and that I have read it, or have it read to me and that I understand its contents.

You have both the right and obligation to make decisions concerning your health care, your physician can provide you with the necessary information and advice, but as a member of the healthcare team, you must enter into the decision-making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

Patient or Guardian: Name Print _____

Signature: _____

Date: _____