CONSENT FOR PROSTATE ULTRASOUND/ POSSIBLE BIOPSY

I, _____, hereby authorize {name of Provider} or his assistant to perform the above listed procedure. The risks and benefits have been explained to me by the doctor and/or his assistant to my satisfaction. I also understand that the doctor makes no guarantee as to the success of this procedure in delineating and/or diagnosing the condition that I presented with. In some cases, this procedure will need to be repeated, possibly under anesthesia in an outpatient setting.

Prostate Ultrasound involves the insertion of an ultrasound probe into the rectum. A survey of the prostate will then be performed for the purpose of ruling out cancer of other lesions that may be clinically significant. Risks inherent to this procedure whether a biopsy is performed or not include persistent rectal pain, hematospermia (blood in semen), bleeding from the urethra and/or rectum (potentially requiring intervention for control), painful sexual activity, de novo or worsening or urinary symptoms, and infection (potentially resulting in mortality {death}, albeit in rare occurrences despite being given antibiotics). Certain clinical scenarios arise where, even if a biopsy is taken and returns negative, the procedure might need to be repeated if the clinician remains highly suspicious for prostate cancer.

I acknowledge that I followed the pre-procedure instructions and took my antibiotics as instructed. I also stopped all blood thinners as instructed (ie. Coumadin, plavix, and/or Aspirin). I understand that I will be given appropriate post-procedure instructions and will do my best to comply with them along with following up at the appropriate post-procedure interval. I know to call the doctor immediately for any of the side effects mentioned above, especially high fever, profuse bleeding, and/or pain.

_____ _____ _____

Patient Signature Date Witness