Patient's sticker

Version 08/16

Consent Form For

NEEDLE BIOPSY / CORE NEEDLE BIOPSY OF THE PROSTATE GLAND

Needle biopsy of the prostate is performed in order to obtain a sample of tissue or cells in order to determine a diagnosis and/or to assess the extent of the changes/disease degree in the prostate and the extent of the spread of the disease. The needle biopsy is performed using a needle designed for this purpose. Usually the needle biopsy is performed under imaging instruments, often ultrasound through the rectum. With the needle, inserted under the ultrasound guidance cells/tissue are extracted and delivered to cytological, pathological examination and/or culture testing.

In most cases, the duration of the operation is a few minutes. There are cases where it is impossible to extract enough tissue for testing and the operation will need to be repeated.

The need for anesthesia shall be decided based on the age of the patient and the type of acupuncture. In some cases the following type of anesthesia will be performed in this operation (circle the appropriate):

Without/General/Regional/Local anesthesia

Patient Name:

Last Name	First name	ID.	Father's Name

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I hereby declare and confirm that I received a detailed oral explanation from Dr.:

Last Name First name

on the need for NEEDLE BIOPSY / CORE NEEDLE BIOPSY OF THE PROSTATE GLAND (hereinafter: the "Primary treatment").

I was also explained about the available alternatives to the primary treatment.

I hereby declare and confirm that I was informed of the side effects of the examination, including: Pain and discomfort, prolonged pain in the rectum area, burning sensation during urination and blood from the rectum or in the urine. During the days following the examination blood may appear in the ejaculatory fluid. This phenomenon is not alarming and stops by itself without treatment.

Also, I received an explanation concerning the possible risks and complications, including infection of the urinary tract and prostate that might yield the need for hospitalization in a hospital for treatment, continuous bleeding from the rectum or in the urine, which may in some cases result in the need for hospitalization for observation purposes. Rarely, the bleeding will require blood transfusion or surgery to stop the bleeding. The biopsy may cause urinary retention and inability to urinate independently - a condition that would require draining the bladder through a catheter, for a certain period. Rarely, damage may be caused to adjacent organs that will necessitate surgical treatment.

I hereby declare and confirm that I have been informed and that I understand that there is a possibility that during the primary diagnostic procedure it will become necessary to extend its scope, change it or take other or additional procedures to save lives, prevent physical damage, including additional surgical operations that cannot be foreseen, yet their implication was explained to me. Therefore, I also agree to that extension, modification or to the performance of other or additional procedures, including surgical procedures that in the opinion of the hospital physicians will be necessary or vital during the primary surgery.

I have been informed that if the operation is performed under general anesthesia/regional anesthesia/ nerve block

an explanation on the method of anesthesia shall be presented to me by an anesthesiologist.

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If the surgery is performed under local anesthesia, I also consent to performing local anesthesia with or without intravenous injection of sedatives after I have been informed of the risks and complications of local anesthesia, including an allergic reaction to varying degrees of anesthesia and possible complications of using sedatives, which might rarely cause respiratory disorders and heart arrhythmia, especially in patients with heart disease and patients with respiratory disorders.

I know that if the medical center has a university branch, student may take part in the assessment and treatment procedures, under full supervision.

I know and agree that the examination and all the primary procedures will be performed by whoever is assigned to conduct them according to the procedures and instructions of the Medical Center, and that I have not been promised that they will be done, neither in whole nor in part, by a certain specific person, provided they are conducted with the acceptable responsibility and subject to the law.

I hereby grant my consent to perform the primary treatment.

Date	Time	Patient Signature

Guardian's name (relatedness to the patient)	Guardian's signature (in the case of an incompetent minor or mentally ill)

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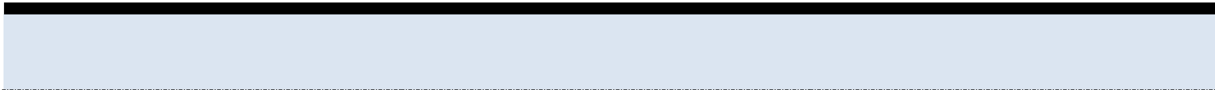
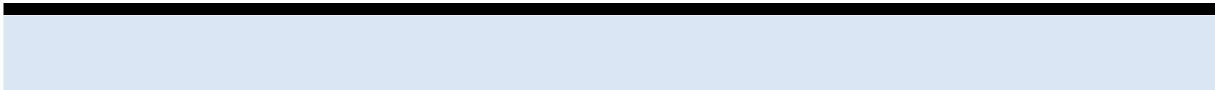
I confirm that I orally explained to the **patient/guardian/patient's translator** all the above in the required detailing, and that he/she signed a consent before me after I was convinced that he/she fully understood my explanations.



Physician's name (stamp)	Physician's signature	Date and time



Translator's name	His relatedness to the patient