

South Sound Radiologists, Inc., P.S.

INFORMED CONSENT

STEREOTACTIC BREAST BIOPSY

Washington State law guarantees that you have both the right and obligation to make decisions concerning your healthcare. Your clinician (physician or healthcare provider) can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your clinician.

Patient: _____ **Patient #:** _____

I hereby authorize Dr. _____ and/or such associates or assistants as may be selected by the aforementioned physician to perform a **STEREOTACTIC BREAST BIOPSY**.

PROCEDURE: Stereotactic breast biopsy uses x-rays in conjunction with a computer to position a biopsy needle inside your breast. With this needle and guidance system, our radiologist will obtain samples of tissue from the abnormal area in your breast. After the biopsy a metallic clip may be placed at the biopsy site for future mammographic reference.

RISKS: All procedures carry some risk. Most patients experience only mild discomfort during the breast biopsy procedure. Occasionally during one of the biopsy passes, a moment of pain is felt with the biopsy of a small nerve. These moments of pain are infrequent and unpredictable. Because a needle is entering your breast, the possibilities of infection, bleeding, or vessel injury at the biopsy site exist but are uncommon. There is a risk of prolonged chest wall/rib pain due to positioning. If a metallic clip is placed, the clip could be placed inaccurately or could migrate away from the biopsy site. Because we use local anesthesia to numb the skin prior to the procedure, there may be a risk of allergy to the medication we use for anesthesia. If you have had a prior abnormal reaction to any medical or dental procedure from anesthesia, please inform us. There is a small chance that the lesion will not be adequately sampled. If you have breast implants, there is a small risk of implant rupture.

EXPECTED OUTCOME: As a result of this stereotactic core breast biopsy, a definitive diagnosis is expected. The chances are greater than 95% that we will reach a definitive diagnosis with your biopsy. Following stereotactic breast biopsy, you may have tenderness at the site of the biopsy, bruising in the skin, or a slight oozing/bleeding for several days. This is not unusual. In almost all instances, the biopsy site can be properly dressed with a Band-Aid. If the biopsy result is benign (not malignant), we will make a recommendation to your healthcare provider regarding your follow-up. If the result of the biopsy is breast cancer, your doctor will recommend the next step in your treatment.

BENEFITS: Diagnosis of disease process with a smaller amount of tissue, avoidance of surgical scar and reduced recovery time when compared to surgical excisional biopsy. This procedure allows possible avoidance of surgery if the biopsy results are benign (not cancer) and appropriate surgical planning if biopsy results are positive for cancer.

ALTERNATIVES TO PROCEDURE: Surgical breast biopsy in which the abnormal area is first localized with a mammographic or ultrasound procedure and then the abnormal area is excised by surgery. The other alternative is to have nothing done realizing that the lesion may indeed represent breast cancer which would lead to a delay in the diagnosis and treatment of breast cancer.

BIOPSY RESULTS: Your referring clinician will provide biopsy results and our final recommendation. Results will typically be available in 2-5 working days. If you have not heard from your clinician within one week, you should call their office and inform them you had a biopsy and are awaiting the results. If you have any problems receiving your results, you should give our office a call and we will get in touch with your clinician so that you receive your results.

You always have the right to refuse any procedure at any time. It is your responsibility to inform us if you do not want the procedure or wish to stop during the procedure after it has started. It is also your responsibility to inform us of any prior adverse outcome or reaction to a similar study or x-ray dye/anesthetic.

Patient/Other Legally Responsible Person Signature

Witness Initials

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I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I, therefore, authorize the above-named physician, and his or her assistants or designees, to perform such procedures as in his or her professional judgment are necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of the medical procedure is commenced.

I have viewed and understand the Stereotactic Breast Biopsy Video. _____
Date Signature

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

Patient/Other Legally Responsible Person Signature / / _____
Date Witness

Radiologist Signature