



**ST. VINCENT'S MELBOURNE**  
**CT GUIDED SOFT TISSUE BIOPSY**  
**PROCEDURE CONSENT FORM**

UR No.:	_____
Surname:	_____
Given Name:	_____
D.O.B.:	_____
Please fill in if no Patient Label available	

Your treating doctor has asked us to perform a:

Left                  Right                  Not Applicable                  *(hospital to circle, as appropriate)*

*(hospital to insert procedure name)*

Your treating doctor has decided that the benefits you might get from this procedure are far more important than the risks.

Although very unlikely, the possible risks and complications include:

- Bleeding                  • Weakness or numbness                  • Allergy
- Infection                  • Damage to surrounding structures                  • Variable or incomplete pain relief

Please complete this section and **bring this form in with you** on the day of your procedure:

I understand the proposed procedure and acknowledge the risks of the procedure.  
 I understand that I will have the opportunity to discuss and clarify any concerns or questions with the doctor on the day of the procedure.

**Further questions to complete:** please notify one of our nurses by phone on **9231 3654** if you answer "Yes" or "Unsure" to any of these questions:

**Patient to complete**

Are you on blood thinning medication?	No	Yes	Last dose	_____
Any allergies to medications?	No	Yes	Details	_____
Any allergies to dressings?	No	Yes	Details	_____
Do you have a history of diabetes on medication?	No	Yes	Details	_____
Are you pregnant?	No	Yes	Unsure	_____

Patient signature: \_\_\_\_\_ Patient PRINT name: \_\_\_\_\_ Date: \_\_\_\_\_

*Hospital doctor to sign on the day of the procedure (below)*  
 Treating doctor signature: \_\_\_\_\_ Treating doctor PRINT name: \_\_\_\_\_ Date of procedure: \_\_\_\_\_