ADVANCED UROLOGY
CENTERS OF NEW YORK
A Division of Integrated Medical Professionals, PLLC

Mitchell I. Buchbinder, M.D., F.A.C.S.
Michael M. Ziegelbaum, M.D., F.A.C.S.
Michael A. Levine, M.D., F.A.C.S.
Elliot M. Paul, M.D., F.A.C.S.

Lake Success Division

2001 Marcus Avenue
Suite #N214
Lake Success, NY 11042

Telephone: 516-437-4228
Facsimile: 516-355-0637
www.AUCNYLakeSuccess.com

Prostate Biopsy Consent Form

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure so that you may decide whether or not to undergo the procedure after knowing the risks involved and any treatment alternatives available to you. This information is not meant to alarm you; it is an effort to make you better informed so that you may give or withhold your consent to the procedure. If you do not understand any of the information provided, ask your physician to explain it to you.

1. **REASON FOR THE PROCEDURE:** I (we) voluntarily request my physician, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my condition: **To examine the prostate for cancer.**

2. **PROCEDURES:** I (we) understand that the following surgical procedure(s) is planned for me on or about _____
I voluntarily consent to:

Transrectal Ultrasound Guided Needle Biopsy of Prostate

3. **PROCEDURE DESCRIPTION:** An ultrasound probe is placed in the rectum. The probe is about the size and shape of a finger. Ultrasound uses sound waves to make images. The images help view and measure the prostate. A needle is placed through the probe. Your doctor uses the images to guide the needle in talking tissue samples of your prostate. The tissue samples are examined for cancer.

4. **MATERIAL RISKS:** Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the surgical, medical and / or diagnostic procedure(s) planned for me, including, but not limited to:

   a. Bleeding in urine
   b. Infection (possibly requiring hospitalization)
   c. Blocked urine flow
   d. Blood in ejaculate
   e. Persistent pain or discomfort
   f. Bleeding from rectum
   g. You may have cancer and the biopsy may not detect it.

5. **ALTERNATIVES TO PROCEDURE:** The following practical alternatives to this procedure, including the risks and benefits of those alternatives, have been discussed with me:

   a. Watching and waiting with your doctor
   b. Decline having the procedure

6. **LIKELY OUTCOME IF NO TREATMENT:** I have been informed of the likely outcome if no treatment is provided, as follows: Your doctor may not be able to find out what is wrong. Your doctor may not be able to recommend treatment. You may have cancer that is not diagnosed, which could delay your eventual treatment.

7. **TREATMENT LIMITATIONS:** I impose no specific limitations or prohibitions regarding treatment.

8. **DISPOSAL OF TISSUE:** I (we) authorize the disposal of any surgically removed tissue or parts resulting from the procedure according to the accustomed practice.

   a. In conjunction with my prostate biopsy, I understand that a buccal (cheek) smear specimen will be taken from my mouth and be used for DNA confirmation of a positive biopsy report. I understand that my DNA samples on the buccal smears will be stored at a forensic DNA laboratory and destroyed after a period of two years. I understand that the DNA laboratory does not share my DNA information with anyone or use it for any purpose other than matching my biopsy tissue and my reference sample.

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9. CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS: I (we) understand that my physician may encounter or discover other or different conditions which will require additional or different procedures than those planned. I (we) authorize my physician, and associated technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

10. OUTCOME: I understand that it is my responsibility to contact my doctor to review my test results, and acknowledge that no warranty or guarantee has been made to me as to result or cure.

11. PREPARATION: I (we) acknowledge that pre-procedure instructions have been provided regarding antibiotics and enemas, and I have stopped blood thinners (such as aspirin, Plavix and Coumadin (Warfarin) as directed.

CONSENT:
I (we) have been given sufficient opportunity to ask questions about my condition, alternative treatments, risks of treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I (we) have sufficient information to give this informed consent. I hereby consent to the procedure described above.

Patient Name: _____ **Signature:** _____

Witness: _____ **Signature:** _____

Physician: _____ **Signature:** _____

Date: _____