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**Consent to Treatment**

I consent to have \_\_\_\_\_ perform a fine needle aspiration biopsy of a thyroid nodule.

**Verification of procedure to be performed (Physician initial)** \_\_\_\_\_

I know that \_\_\_\_\_ may need the help of other members of the health care team to perform this procedure or treatment.

I acknowledge that \_\_\_\_\_ and I have talked about the above procedure/treatment and its risks and benefits. I understand all of these.

If there are any conditions or problems found during the above-described procedure/treatment, I consent to having \_\_\_\_\_ perform any other related or ancillary procedures, which in his/her opinion are reasonably necessary.

I consent to the administration of anaesthesia, if required, by or under the supervision of a qualified member of the clinic's medical staff.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Physician Performing Procedure

\_\_\_\_\_  
Signature of Physician's Assistant

\_\_\_\_\_  
Date (year/month/day)