
CONSENT TO TREATMENT FOR BREAST BIOPSY

I _____ consent to an ultrasound guided breast biopsy

Printed name of patient ! substitute decision maker

which may include the administration of blood and blood products and anesthetics as necessary for treatment.

I confirm that the risks, side effects, alternative courses of action, material effects and consequences of having or not having the proposed treatment have been discussed with me and that _____ Dr. Alnashir Ismail _____ has responded to my questions.

Name of Health Practitioner

I also consent to such variations and adjustments to the agreed upon treatment as in the opinion of _____ Dr. A. Ismail _____ are immediately necessary.

Name of Health Practitioner

Printed name of patient

Signature of patient

Date

Printed name of witness

Signature of witness

Date

I confirm that the above information has been discussed with the patient/substitute decision maker. I have responded to any and all questions about the proposed treatment, alternative courses of action, material effects risks and side effects and consequences of not having the treatment.

Signature of Health Practitioner proposing treatment

Date

List of Allergies: _____

List of Medications: _____