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)