First Hill
SURGERY CENTER

☐ Fine Needle Aspiration
☐Core Biopsy
☐Aspiration of cyst, seroma, or abscess
Consent Form

Patient Name: _____ Date of Birth:

Guardian Name (if applicable): _____ Patient ID:

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1) MY PROCEDURE

I hereby give my consent for Dr._____to perform a ☐Fine Needle Aspiration ☐Core Biopsy ☐Aspiration of cyst, seroma or abscess upon me. I understand the procedure is to be performed at First Hill Surgery Center. This has been recommended to me by my physician in order to diagnose and/or treat_____.

I understand that the procedure or treatment can be described as follows:

The affected area may be numbed with local anesthesia. The affected area will be sampled and/or drained by inserting a needle into the mass or fluid collection. The fluid or cellular tissues may be sent for pathologic investigation and/or culture to guide further therapy. In some cases, the wound may be closed with sutures to promote healing.

2) MY BENEFITS

Some potential benefits of this procedure include:

- Information to guide further therapy; reduced swelling and/or discomfort related to the mass or cyst.

While a ☐Fine Needle Aspiration ☐Core Biopsy ☐Aspiration of cyst, seroma or abscess is often effective treatment, not all conditions, diseases or problems can be diagnosed or treated solely by a ☐Fine Needle Aspiration ☐Core Biopsy ☐Aspiration of cyst, seroma or abscess.

3) MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.

These could include but may not be limited to the following:

- Bleeding, either immediate or delayed, possibly requiring re-operation; infection at the surgical site, possibly requiring further treatment and/or surgery; post-operative pain, both acute and chronic; recurrent cyst/seroma/abscess requiring further treatment.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

4) MY CONSENT

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to over the counter medications, other surgical techniques and/or other modes of investigation such as ultrasound or x-ray tests. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed ☐Fine Needle Aspiration ☐Core Biopsy ☐Aspiration of cyst, seroma or abscess and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ **Date:** _____ **Time:** _____

Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time: _____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ **Date:** _____ **Time:** _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ **Date:** _____ **Time:** _____