North East Wales NHS Trust

Transrectal Ultrasound (TRUSS) Prostatic Biopsy Consent Form

Surname	
First name	
NHS/hospital no.	
Date of birth	____/____/______

Special communication requirements (e.g. need for interpreter, visually impaired)	
Proposed procedure or course of treatment: (include brief explanation if medical term not clear) Ultrasound guided biopsy of the prostate gland. This is the removal of small pieces of prostatic tissue through a Transrectal Ultrasound guided probe for microscopic examination.	
Other procedures/treatment which may become necessary during the procedure:	To deal with complications if they occur
Anaesthetic: ❐General ❐Spinal ❐Local	**Blood transfusion:** Rarely if bleeding excessive

Statement of health care professional (to be filled in by health care professional with appropriate knowledge of proposed procedure, as specified in Consent Policy)

I have explained the procedure to the patient. In particular, I have explained the following.

Benefits: the intended benefits of this procedure/treatment are:

- Diagnosis of prostatic disease / cancer

Risks: Common

- Blood in the urine
- Blood in the stools
- Sensation of discomfort from the prostate due to bruising
- Urinary infection (10% risk)
- Blood in the semen (may last for up to 6 weeks)

Occasional

- Blood infection (septicaemia) requiring hospitalisation (1% risk)
- Haemorrhage (bleeding) requiring hospitalisation (1% risk)
- Failure to detect a significant cancer of the prostate
- The procedure may need to be repeated if the biopsies are inconclusive or your PSA level rises at a later stage
- Inability to pass urine (retention of urine)

Rare

- Damage to blood vessels or bowels from biopsy
- Chronic pain in penis or perineum
- Extensive haemorrhaging

Alternatives: I have also discussed what the procedure is likely to involve and any concerns of this patient. I have also discussed having no treatment and the following alternatives:-

-
-

Further supporting information - I have provided the following leaflet ________________________________

Signature……………………..……..Name (PRINT)…………………………………………………..Date___/___/_____
Job title……………………………………Contact Details…………………………..…………………………………..

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient, to the best of my ability, and in a way in which I believe they can understand.

Signature……………………..……..Name (PRINT)…………………………………………………..Date___/___/_____

Confirmation of consent by a health professional on admission of the patient, if the patient has signed the form in advance. On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature……………………..……..Name (PRINT)…………………………………………………..Date___/___/_____
Job title……………………………………

One copy of this form must be retained in the Health Record
- another copy has / has not been accepted by the patient.

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Transrectal Ultrasound (TRUSS)
Prostatic Biopsy Consent Form

Surname	
First name	
NHS/hospital no.	
Date of birth	
	_____/_____/_______

Statement Of Patient

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask – we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

- **I agree** to the procedure or course of treatment described on this form.
- **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.
- **I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)
- **I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.
- **I agree** that any tissue removed and the results of diagnostic tests may be used for teaching, audit and research that could benefit other patients.
- **I have been told about** additional procedures, which may become necessary during my treatment. I have listed below any procedures, which **I do not wish to be carried out** without further discussion.
  ………………………………………………………………………………………………
  ………………………………………………………………………………………………
  ………………………………………………………………………………………………
  ………………………………………………………………………………………………

Signature………………………..Name (PRINT)…………………………………..Date___/___/_____

A **witness** should sign below if the patient is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes).

Signature………………………..Name (PRINT)…………………………………..Date___/___/_____

Important Notes: (tick if applicable)

☐ See also advance directive/living will

☐ Patient has withdrawn consent (ask patient to sign /date here)

Signature………………………..Name (PRINT)……………………………… …Date___/___/_____

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- another copy has / has not been accepted by the patient.