UROLOGY SPECIALISTS OF NEVADA

*Robert B. McBeath, M.D., F.A.C.S. * Mark E. Leo, M.D., F.A.C.S. * H. Tamiko Housley, M.D., F.A.C.S. * Jason N. Zommick, M.D., F.A.C.S.
*Michael P. Finkelstein, M.D. * Mulugeta D. Kassahun, M.D. *Kristin M. Sanderson, M.D., M.P.H.* Andrew H. Hwang, M.D., F.A.A.P., F.A.C.S.

PROSTATE ULTRASONOGRAPHY / BIOPSY
PROCEDURE CONSENT

Dr. Robert B. McBeath, Dr. Mark E. Leo, Dr. H. Tamiko Housley, Dr. Jason Zommick, Dr. Michael Finkelstein, Dr. Mulugeta Kassahun, and/or Dr. Andrew Hwang have recommended an ultrasound evaluation of your prostate. A special probe is inserted into the rectum and passes sound waves into the prostate. The picture obtained allows the physician to examine the prostate in great detail.

Your physician may want to perform a biopsy of the prostate. A small needle is inserted through the rectal probe and directed toward the prostate. There may be some discomfort upon insertion of the needle, but the biopsy is generally well tolerated.

You will be given some antibiotic pills to take after your biopsy. It is not unusual to see a small amount of blood in the stool, urine, or semen for a few days after the procedure.

Complications of prostate needle biopsy include heavy bleeding in the urine or stool, fever, chills, or severe infection. Should any of these occur, **please notify our office immediately.**

By signing this form you are consenting to the performance of prostate ultrasounding and needle biopsy. You also consent to treatment for any of the complications which may occur.

"I understand, acknowledge, and agree to the forgoing and state that I have had the opportunity to ask any questions which I may have concerning the procedure being performed and all questions have been answered to my satisfaction."

Print Patient's Name:____

Patient Signature:________________________________**Date**:_____________

"I understand if a biopsy is performed, the tissue will be sent to an outside laboratory who will bill me, the patient, or my insurance company separately for examination of the tissue."

Patient Signature:________________________________**Date**:_____________

"I have explained the procedure above and have explained the risks, benefits, and alternatives to the patient. The patient has indicated understanding of the explanations given, and consented to the performance of the special procedure requested.

Physician's Signature:_____________________________**Date**:_____________

5701 W. Charleston Blvd, Suite 201, Las Vegas, NV 89146
56 N. Pecos, Suite B, Henderson, NV 89014
Phone: (702) 877-0814 Fax: (702) 877-3238