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Patient Consent for Transrectal Biopsy of the Prostate

Patient Name: _____ Date of Birth: _____

Procedure: Transrectal Biopsy of the Prostate _____ Date of Procedure: _____

I, _____ have discussed the risks, benefits, and alternatives to the procedure and fully understand the risks associated with this procedure.

- The risks include, but are not limited to: infection and bleeding. This may require antibiotic therapy and the possible need for hospitalization.
- I also understand that there is a possibility of seeing blood in my urine, ejaculate, and bowel movements.
- I understand that I am to contact the office or go to the emergency room if I develop a fever, shaking, chills, nausea, vomiting or bleeding.
- There is also a possibility of developing difficulty in urinating, possibly requiring the placement of an indwelling catheter.

Patient Signature: _____

Witness Signature: _____

Physician Signature _____ Date/Time: _____