

McLAREN REGIONAL MEDICAL CENTER
Flint, MI 48532
DEPARTMENT OF RADIOLOGY
CONSENT FOR DIAGNOSTIC PROCEDURE

Physician: _____

Patient's Name: _____

This paper serves as a legal document concerning the following procedure:

My signature on this document indicates my willing consent to the above named diagnostic procedure.

The nature, benefits, as well as the risks of this procedure, including the possibility of bleeding, possible hematoma, and infection have been fully explained to me. If you have breast implants, there is a possibility of implant rupture. Other options including open surgical biopsy have been explained to me. Percutaneous needle biopsy being performed today will likely remove only a portion of the lesion in question. If the lesion is determined to be benign, then normally a short-term follow-up in approximately 6 months will be performed to ensure stability of the finding. The above named physician has answered any questions that I may have had to my satisfaction.

I authorize the named physician or his/her designees to initiate the proper and immediate course of action or treatment that may be necessitated if unforeseen conditions or events occur.

Patient/Legal Guardian Signature: _____ Date: _____ / _____ / _____

Physician Signature: _____ Time: _____ Date: _____

Time Out: _____

Technologist Signature: _____

Date: _____ / _____ / _____

Post Instructions

Time: _____ Date: _____

Patient Signature: _____

Technologist Signature: _____

Physician Signature: _____

<p>PHYSICIAN ONLY</p> <p>Current procedure documents verified</p> <p><input type="checkbox"/> Order</p> <p><input type="checkbox"/> PAT</p> <p>Date/Initials _____</p>



PT.

MR.#/RM.

DR.