Consent for Liver Biopsy

1. I hereby authorize _______________________________ and whomever he/she may designate as assistant(s) to administer such surgical treatment is necessary to perform upon myself a percutaneous liver biopsy.

2. Possible alternative methods of treatment have been fully explained to me and the nature and purpose of this surgical procedure has been explained to me. I understand the nature and purpose of this procedure to be to determine the stage and grade of hepatitis for the purpose of evaluating for treatment eligibility.

3. I consent to the performance of the above surgical procedure in addition to or different from those now contemplated, whether or not arising from presently unforeseen condition, which the above-named physician or designee may consider necessary or advisable in the course of the above surgical treatment.

4. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. I understand that the results of the liver biopsy may show that treatment is not needed in my case.

5. The risks involved, the possible consequences, and the possibility of complications have been fully explained to me. These include excessive bleeding; bleeding under the liver capsule; unintentional puncture of bowel or other internal organs; collapse of a lung; shock; and death.
   a) In the event of puncture of an internal organ, major abdominal surgery for exploration and repair will be required. In some cases, a colostomy (diverting stool contents into a bag attached to the abdominal wall) will be necessary, either for several months or permanently.
   b) In the event of a collapsed lung, emergency insertion of a chest tube will be required. A chest tube is inserted through the chest wall between the ribs using a local anesthetic, and is left in place for several days until the lung heals.

6. I consent to the administration of a local anesthesia to be applied by or under the direction of the above-named physician or his designee, and the use of such local anesthetics, as he may deem advisable.

7. The risks of the local anesthetic have been explained to me, which are increased bleeding, local infection, decreased blood pressure or heart rate, and allergic reaction.

8. I consent to the disposal, by the health service authorities, of any tissue or body parts, which may be removed and disposed of in accordance with accustomed practice.

9. The above consent is informed and freely given and is not the result of coercion.

10. I have read or had read to me and fully understand the above consent to surgical treatment, that the explanations herein referred to were made and that all blanks or statements requiring insertion or completion were filled in before affixing my signature.

Medical Provider’s Signature __________________________________Date ______________
Witness___________________________________________________Date______________
Offenders Signature____________________ DOC # ______________Date______________