BERKELEY
ENDOCRINE CLINIC
Hormonal Health and Wellness

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INFORMED CONSENT

ULTRASOUND-GUIDED THYROID FINE NEEDLE ASPIRATION

Patient: _____ **Patient DOB**_____

I hereby authorize Dr OMAR MURAD, to perform an **ULTRASOUND-GUIDED THYROID FINE NEEDLE ASPIRATION** on my thyroid.

PROCEDURE: Ultrasound guided fine needle aspiration uses ultrasound to position a small needle inside your thyroid (neck). With this needle and ultrasound guidance, Dr Murad will obtain fluid samples from the abnormal area in your thyroid.

RISKS: All procedures carry some risk. Most patients experience only minimal discomfort during the procedure. Because a needle is entering your thyroid, the possibilities of pain, infection, bleeding, and rarely, vessel injury exist. Because we use Topical Anesthesia to numb the area prior to the procedure, there may be a risk of allergy to the medication we use for anesthesia. Rarely, you may notice a temporary voice change. There is a chance that adequate cells will not be obtained for definitive diagnosis requiring additional fine needle aspiration.

BENEFITS: Diagnosis of the cause of the thyroid nodule.

ALTERNATIVES TO PROCEDURE: Fine needle aspiration without ultrasound guidance, no procedure, and surgical removal.

CYTOLOGY RESULTS: Patients are advised to schedule a visit with the clinician one week after the biopsy to check on the site of the biopsy and to discuss the results of the biopsy.

You always have the right to refuse any procedure at any time. It is your responsibility to inform us if you do not want the procedure or wish to stop the procedure after it has started. It is also your responsibility to inform us of any prior adverse outcome or reaction to a similar study or anesthetic.

I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I, therefore, authorize the above-named physician, and his or her assistants or designees, to perform such procedures as in his or her professional judgment are necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of the medical procedure is commenced.

I certify that I have read this form, or have had it read to me, and that I understand its contents.

_____ _____

Patient/Other Legally Responsible Person Signature Date/Time