(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

Stereotactic Biopsy of Cerebral Space Occupying Lesion

Facility: ....

A. INTERPRETER / CULTURAL NEEDS

An Interpreter Service is required? ☐ Yes ☐ No

If *Yes*, is a qualified Interpreter present? ☐ Yes ☐ No

A Cultural Support Person is required? ☐ Yes ☐ No

If *Yes*, is a Cultural Support Person present? ☐ Yes ☐ No

B. CONDITION AND TREATMENT

The doctor has explained that you have the following condition: *(Doctor to document in patient's own words)*

....

....

This condition requires the following procedure/ treatment/investigation. *(Doctor to document - include site and/or side where relevant to the procedure)*

....

....

The following will be performed:

This procedure is performed to take a small sample of the lesion inside your brain. It is taken to identify the lesion which then determines the appropriate treatment for you.

A small cut is made in the skin which allows a small hole to be drilled into the skull beneath the cut. The firm lining of the brain will be opened.

Using computer guidance a thin biopsy needle is passed into the lesion within the brain. Small samples of the lesion are taken and sent to pathology for examination.

The cut is closed with stitches and staples.

C. RISKS OF A STEREOTACTIC BIOPSY OF CEREBRAL SPACE OCCUPYING LESION

There are some risks/complications with this procedure/treatment/investigation.

Common risks include;

- Infection. This may need antibiotics and further treatment.
- Minor pain, bruising and/or infection from IV cannula site. This may require treatment with antibiotics.
- A pathology result may not be able to be obtained from the sample. This may require further surgery or another biopsy.
- Bleeding. A return to the operating room for further surgery may be required if bleeding occurs. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Asprin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).

Uncommon risks include;

- A heart attack because of the strain on the heart.
- Fluid leakage from around the brain can occur after the operation. This may require further surgery.
- Small areas of the lung may collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increase risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
- Clots in the leg (deep vein thrombosis or DVT) with pain and swelling. Rarely part of this clot may break off and go into the lungs.

Rare risks include;

- Epilepsy which may require medication. This condition may be temporary or permanent.
- Stroke or stroke like complications can occur which can cause weakness in the face, arms and legs. This could be temporary or permanent.
- Injury to the brain, important nerves or blood vessels. This can lead to stroke like complications which can cause weakness in the face, arms and/or legs.
- Death is rare due to this procedure.

D. SIGNIFICANT RISKS AND PROCEDURE OPTIONS

(Doctor to document in space provided. Continue in Medical Record if necessary.)

....

....

E. RISKS OF NOT HAVING THIS PROCEDURE

(Doctor to document in space provided. Continue in Medical Record if necessary.)

....

....

F. ANAESTHETIC

This treatment/procedure/investigation may require an anaesthetic. *(Doctor to document type of anaesthetic required)*

....

Continues over page ►►►

Stereotactic Biopsy of Cerebral Space Occupying Lesion	(Affix patient identification label here)
	URN:
	Family Name:
	Given Names:
	Address:
Facility:	Date of Birth: Sex: ☐ M ☐ F

G. PATIENT CONSENT

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure/treatment/investigations, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- the anaesthetic required for this procedure/treatment. I understand the risks, including the risks that are specific to me.
- other relevant procedure/treatment options and their associated risks.
- my prognosis and the risks of not having the procedure/treatment.
- that no guarantee has been made that the procedure/treatment will improve my condition even though it has been carried out with due professional care.
- the procedure may include a blood transfusion.
- tissues and blood may be removed and could be used for diagnosis or management of my condition, stored and disposed of sensitively by the hospital.
- if immediate life-threatening events happen during the procedure, they will be treated accordingly.
- a doctor other than the Specialist Neurosurgeon may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheets;

- ☐ **About your Anaesthetic**
- ☐ **Stereotactic Biopsy of Cerebral Space Occupying Lesion**

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure/treatment/ investigations and its risks, and my treatment options. My questions and concerns have been discussed and answered to my satisfaction.
- I understand I have the right to change my mind at any time before the procedure/ treatment/investigation, including after I have signed this form but, preferably following a discussion with my doctor.

On the basis of the above statements,

I REQUEST TO HAVE THE PROCEDURE

Name of Patient/ Substitute decision maker and relationship: ....

Signature: ....

Date: ....

Substitute Decision-Maker: Under the *Powers of Attorney Act 1998 and/or the Guardianship and Administration Act 2000*. If the patient is an adult and unable to give consent, an authorised decision-maker must give consent on the patient's behalf.

H. DOCTOR'S STATEMENT

I have explained to the patient all the above points under the Patient Consent section (G) and I am of the opinion that the patient/substitute decision-maker has understood the information.

Name of Doctor: ....

Designation: ....

Signature: ....

Date: ....

Name of Anaesthetist: ....

Designation: ....

Signature: ....

Date: ....

I. INTERPRETER'S STATEMENT

I have given a sight translation in

....

(state the patient's language here) of the consent form and assisted in the provision of any verbal and written information given to the patient/parent or guardian/substitute decision-maker by the doctor.

Name of Interpreter: ....

Signature: ....

Date: ....