



NAME _____

SEX M F

MR# _____

AGE / DATE OF BIRTH _____

ACCOUNT# _____

(PATIENT PLATE IMPRINT)

**GASTROENTEROLOGY SECTION
CONSENT FOR: LIVER BIOPSY**

Introduction: Your doctor, _____, has scheduled you for an examination of the liver using a liver biopsy needle. The indication (or reason) for the procedure is: _____
We are asking you to read and sign this form so that we can be sure you understand the procedure and the risks. Please ask questions about anything on this form you do not understand.

Procedure: You should have already heard or read a description of the procedure (initialize if so _____). Briefly, with the aid of a topical anesthetic, the biopsy needle will be passed through your right, lateral abdominal wall about one inch into the surface of your liver. The needle will then withdraw a sample of your liver for special, microscopic examination to confirm the cause of your liver disease and determine the amount of damage present. A liver biopsy usually takes less than 10 minutes. You will then lie on your right side for two hours.

Risks: In general, a liver biopsy is a safe test, but does have some risks associated with the procedure and with the anesthesia. The risks associated with the procedure range from minor discomforts to significant medical problems. The minor problems are mainly pain (1/10) that usually resolves in 1-2 hours. The more important risks include: 1) internal bleeding requiring blood transfusions (1/500); 2) biopsy of another organ (1/500) or; 3) necessity for surgery (1/1000) because of #1 or #2.

The very rare risks associated with topical anesthesia are allergic reactions (such as hives, wheezing, anaphylaxis).

Although the overall risks to the procedure are quite small, occurring in less than 1/500 patients, there have been reports of serious, unpredicted complications that include death. (1/5000)

Alternatives: There may be other tests that your physician could use to help diagnose your problem. If you are reluctant to have the liver biopsy, please discuss this with your physician.

Agreement: I understand the information on this form and have had the opportunity to ask my physician any other questions I might have. I agree to have the procedure performed and accept the risk.

Signature: _____ Date: _____ Time: _____
Patient or Relative

Signature: _____ Date: _____ Time: _____
Witness

Signature: _____ Date: _____ Time: _____
Physician



DO NOT USE UNAPPROVED ABBREVIATIONS