



Queensland Government

Biopsy of Cerebral Space Occupying Lesion

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

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. *(Doctor to document - include site and/or side where relevant to the procedure)*

.....
.....

The following will be performed:

- Stereotactic Biopsy Procedure**
- Open Biopsy Procedure**

This procedure is where a small sample or biopsy is taken of a lesion inside your brain. The sample is taken to identify the lesion which then determines the appropriate treatment for you.

C. Risks of a biopsy of cerebral space occupying lesion

There are risks and complications with this procedure. They include but are not limited to the following.

Common risks and complications (more than 5%) include:

- 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.
- The lesion may not be found due to brain shift. This may require further surgery.

Uncommon risks and complications (1-5%) include:

- Infection, requiring antibiotics and further treatment.
- Bleeding can occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs such as Warfarin, Aspirin, Clopidogrel (Plavix or Iscover) or Dipyridamole (Persantin or Asasantin).
- Heart attack due to the strain on the heart.
- Fluid leakage from around the brain may occur through the wound 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.
- Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.

Rare risks and complications (less than 1%) include:

- Epilepsy which may require medication. This condition may be temporary or permanent.
- Stroke or stroke like complications may occur causing neurological deficits such as 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.
- Death as a result of this procedure is very rare.

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 procedure may require an anaesthetic. *(Doctor to document type of anaesthetic discussed)*

.....
.....



Biopsy of Cerebral Space Occupying Lesion

Facility: _____

(Affix identification label here)

URN: _____

Family name: _____

Given name(s): _____

Address: _____

Date of birth: _____

Sex: M F I

G. Patient consent

I acknowledge that the doctor has explained;

- my medical condition and the proposed procedure, 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. 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.
- that no guarantee has been made that the procedure 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 based on my discussions with the doctor or my Acute Resuscitation Plan.
- a doctor other than the Consultant may conduct the procedure. I understand this could be a doctor undergoing further training.

I have been given the following Patient Information Sheet/s:

- About Your Anaesthetic
- Biopsy of Cerebral Space Occupying Lesion
- Blood & Blood Products Transfusion

- I was able to ask questions and raise concerns with the doctor about my condition, the proposed procedure 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, including after I have signed this form but, preferably following a discussion with my doctor.
- I understand that image/s or video footage may be recorded as part of and during my procedure and that these image/s or video/s will assist the doctor to provide appropriate treatment.

Samples of brain tumours are very important for research. If you tick the box below a sample will be sent for research.

- I agree to a sample of my tumour for research and clinical data being kept.
- I agree to having a blood sample taken for research.

On the basis of the above statements,

I request to have the procedure

Name of Patient: _____

Signature: _____

Date: _____

Patients who lack capacity to provide consent

Consent must be obtained from a substitute decision maker/s in the order below.

Does the patient have an Advance Health Directive (AHD)?

Yes ► Location of the original or certified copy of the AHD: _____

No ► Name of Substitute Decision Maker/s: _____
Signature: _____
Relationship to patient: _____
Date: _____ PH No: _____

Source of decision making authority (tick one):

- Tribunal-appointed Guardian
- Attorney/s for health matters under Enduring Power of Attorney or AHD
- Statutory Health Attorney
- If none of these, the Adult Guardian has provided consent. Ph 1300 QLD OAG (753 624)

H. Doctor/delegate 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/delegate: _____

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: _____

DO NOT WRITE IN THIS BINDING MARGIN

