



**CONSENT FORM  
FOR  
TEMPORAL ARTERY  
BIOPSY**

Med Rec. No.....

Surname:.....

Forename: .....

DOB:.....

AFFIX LABEL HERE

**PROPOSED TREATMENT**

The doctor has explained that I, *(name of patient)* .....  
may have **temporal arteritis** and that a **temporal artery biopsy** is proposed:

**This means an operation to remove a short segment of a small artery at the side of my forehead. This operation is for diagnosis only and will not cure or otherwise affect the condition.**

**Under a local anaesthetic, which involves a small injection into the skin at the operation site, the surgeon makes a 1-2cm cut over the pulse that is felt at the hairline just above the ear.**

**Bleeding is minimal, and is easily controlled with pressure. The artery is freed from the tissues around it, and tied off at each end to allow a segment of it to be taken out and sent to the laboratory for examination under a microscope. The wound is closed with absorbable stitches, and a dressing is applied.**



**RISKS**

*The following risks are those that may most commonly occur. There may be other unusual risks that have not been listed here. Please ask your doctor if you have any concerns.*

I understand the procedure has the following **general risks and limitations**:

- I will have a scar where the operation was performed. This usually fades over some weeks.
- My wound may rarely become infected, becoming red painful, swollen and possibly developing a discharge. I may need antibiotics if this happens
- The chance of bleeding is low, but bruising can be minimised by keeping pressure on the dressing for a few hours.

**INDIVIDUAL RISKS**

I understand the following are possible significant **risks and complications specific to my individual circumstances** that may affect my decision to agree to have the proposed treatment:

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.....

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**DECLARATION BY PATIENT**

- I acknowledge the surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the surgeon any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than the specialist surgeon may perform the procedure.
- I have received a copy of this form to take home with me.
- If any staff member is exposed to my blood (needlestick injury) then I consent to a sample of my blood being collected for testing for infectious diseases, such as Hepatitis B, C and HIV. I understand that the blood sample will not be tested until I have been informed and I have given my consent.

Signature of patient

Date

*If the patient is an adult and unable to give consent, a proxy form must be completed and attached*

**DECLARATION BY DOCTOR**

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature

Doctor's name

*(please print)*

Date

**INTERPRETER'S DECLARATION** - I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's  
Signature

Date

Interpreter's name  
*(please print)*