Jeri Shuster, M.D., P.A.
and Women's Center, Inc.

Jeri Shuster, M.D., Fellow of the American College Obstetricians and Gynecologists
Kathryn Cervi, C.R.N.P., Women's Health Care Nurse Practitioner

INFORMED CONSENT: FINE NEEDLE ASPIRATION BREAST CYST

I hereby request and authorize Dr. Jeri Shuster to perform upon me the procedure:
fine needle aspiration of breast cyst.

This procedure involves placing a needle attached to a syringe into the breast to drain fluid. This is done in an effort to alleviate pain caused by the cyst. It may also be done to help distinguish between a cystic vs. solid breast mass. Fluid is withdrawn and tested for microscopic and visible blood. If no blood is present, the fluid is innocent and is discarded. If blood is present, the fluid is sent to the lab for study.

Risks include: bleeding, infection, pain, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition, injury to adjacent structures such as ribs, muscles, lung. To reduce risks of bleeding and persistence of the cyst, a pressure dressing will be placed over the aspiration site. Wear this dressing plus a tight bra for 24 hours following the procedure. After that, keep the area clean and dry.

Benefits may include achieving a diagnosis and alleviating pain.

Alternatives include: not doing the procedure, excisional biopsy with removal of the entire cyst or lump.

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment.

I have been given ample time to make my decision to undergo this procedure. I have been given the opportunity to consult with other physicians concerning my condition and the treatment if I so desire.

I understand that circumstances could arise during the course of treatment which could necessitate the performance of operations and procedures which are different from, or in addition to, those now contemplated. I am aware that the practice of medicine and surgery are not exact sciences and that there are risks and complications associated with this procedure. The possibility of severe blood loss, infection, injury, and cardiac arrest could be associated with this procedure. I authorize my physician or her assistants to perform additional procedures which, in their judgment, are incidentally necessary to carry out my treatment.

I authorize the emergency administration of blood or blood products.

I authorize the examination by an authorized individual of any tissue or sample removed from my body as a result of the procedure(s) as well as disposal of same.

I understand that I have the right to refuse any medical or surgical procedures or treatment.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND HAVE NO FURTHER QUESTIONS WHICH I NEED ANSWERED PRIOR TO THE PROCEDURE AND THAT ALL THE BLANKS ON THIS FORM HAVE BEEN FILLED IN.

Patient / Guardian Signature	Date
Witness Signature	Date
Jeri Shuster MD / Kathryn Cervi CRNP	Date

410.730.5700 (Tel) • 410.964.3231 (Fax) • 11085 Little Patuxent Pkwy, Suite 204 • Columbia, MD 21044-2979
www.jerishustermd.com