



INFORMED PATIENT CONSENT FOR SCROTAL ULTRASOUND

Name _____ DOB _____

Address _____

Patient Information

Your doctor has requested us to perform a scrotal ultrasound. It is important that you understand the procedures that is associated with this examination:

- During the procedure your scrotum will be exposed whilst the Sonographer completes the examination.
- A third person may be present during the examination acting as a chaperone should you desire.

Questionnaire

Do you have any family history of testicular cancer? ☐ Yes ☐ No

If yes, state the relationship _____

Reason for having this ultrasound _____

Date of previous ultrasound if any _____

Are these films available for comparison? ☐ Yes ☐ No

Patient Consent

I read the above explanation and understand and accept the procedure. I hereby consent to the performance of a scrotal ultrasound.

Signature _____ Date _____
(Patient)

Name _____
(Interpreter if present)

Signature _____ Date _____
(Interpreter if present)