DR. LINDA J. WARREN AND ASSOCIATES
DIAGNOSTIC RADIOLOGY, MAMMOGRAPHY, ULTRASOUND

SUITE 505, 750 WEST BROADWAY, VANCOUVER, B.C. V5Z 1H4
TELEPHONE: 879-4177 • FAX: 879-4147

CONSENT FOR BREAST CORE BIOPSY

I, the undersigned, do hereby consent to the following procedure:

_____

To be performed upon: _____
(Name of patient)

Under the direction of Dr._____M.D.

I have read the breast biopsy instruction sheet on the reverse of this page, and have had the procedure explained to me by the technologist. I am aware of the complications and have had the opportunity to have any of my questions answered to my satisfaction.

I understand and agree that the procedure requires the cooperation of technologists and other personnel of *Dr Linda J. Warren and Associates.*

I also consent to any alternative or additional treatments that the above named physicians consider either advisable or immediate.

I also consent to the administration of local anesthetic and other medications deemed advisable by the radiologist.

Name of Patient (print):

_____

Signature:

_____
(patient or person legally authorized to consent)

Relationship to Patient: _____

Witness: _____ _____
(print) (signature)

Date: _____