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PATIENT CONSENT FORM

PROSTATE CANCER

Wellness Institute & Mammography Center

Street Address City, State Zip (202) 555 - 1212

Welcome to the Hospital Wellness Institute Prostate Cancer Screening Program. The screening will consist of a digital rectal examination (DRE) and, if applicable, a prostate-specific antigen (PSA) blood test. Although the PSA will detect most high-risk cancers, there may be cancers that will be missed by this test and can be detected by the physical exam. Therefore, using both tests together will give your doctor the most accurate information. The health professional will consult with the participant on the day of the examination regarding results of the rectal examination. Results of the PSA blood test will be mailed to you in approximately 8-10 days. If any abnormalities are detected from the test and/or the exam, you will be contacted by phone and referred to a Urologist for further evaluation and treatment.

The American Cancer Society, American Urologic Association and Prostate Cancer Education Council recommend both the prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) be offered annually, beginning at age 50 for average risk men. Men at high-risk (African-American men and men with a strong family history of one or more first degree relatives [father, brothers] diagnosed at an early age) should begin testing at age 45. Men at even higher risk, due to multiple first-degree relatives affected at an early age, should begin testing at age 40.

By voluntarily participating in this Prostate Cancer Screening Program, I recognize and accept all risks associated with it. I understand the PSA blood test (approved by the FDA as a screening test for prostate cancer) and rectal exam will only screen for abnormalities in the region of the prostate and do not constitute a complete medical examination or diagnosis. I also understand the tests may not be 100% accurate; false negative and false positive test results may occur. While these tests find most cancers, there are some types of cancers which go undetected.

I hereby release the American Cancer Society, American Urologic Association, Prostate Education Council, American Foundation for Urologic Disease, Hospital Wellness Institute (staff, physicians, and health care professionals), and other organizations and their agents involved in this Prostate Cancer Screening Program from all liabilities, medical claims or expenses, or any injury which may result from my participation in this program.

I have read this form and understand its contents. I understand the results will be released to me and the confidentiality of the data will be maintained within legal limits.

PATIENT Signature:	(Print Name)	DATE:
WITNESS Signature:	(Relationship)	DATE:
TRANSLATOR Signature: <i>(if applicable)</i>	(Print Name)	DATE:

PART OF THE MEDICAL RECORD