NEAR EAST UNIVERSITY HOSPITAL

# MAMMOGRAPHY PATIENT CONSENT FORM

**Patient Name-Surname:**

**Patient ID:** **D.O.B.:**

**Father's Name:** **ID Number:**

Dear Patient / Patient Relative,
Mammography examination is required to clarify your pre-diagnosis/diagnosis as a result of your physician's evaluation and examinations. This form is to inform you about the examination methods to be applied and designed to keep you informed about the potential risks. Please completely and carefully read this form and give your consent after the physician has informed you about all your doubts, if you have any, regarding the process.

**1. PREDIAGNOSIS/DIAGNOSIS:** ……

**Physician's Name and Surname:** ……..

**2. PROPOSED EXAMINATION: Mammography**

**Age of the patient:** ……..

**Height and weight of the patient:**……cm / ……kg

**Menstrual status:** ……

**Patient's last menstrual period:** ……

**Age of first menstrual period:** ……..

**Age of menopause:** ……

**Number of births:** ……

**Breastfeeding period:** ……..

**Patient's complaint/reason for referral:** ……..

**5. METHOD:**

Mammography is an examination method that uses X-rays (ionizing radiation). During the examination, your breast tissue will be compressed between two plates. The compression process is performed to reduce the breast thickness and to provide a better view of breast tissue. The compression procedure is usually painless, but some patients may feel a small amount of pain.

**6. RISKS OF THE PROPOSED EXAMINATION:**

The risks associated with the examination are minimal. X-ray radiation may slightly increase the risk of developing cancer later in life in people exposed to X-rays. The potential for wellness is almost the same as for others in conditions similar to yours.
X-rays have a feature of ionizing radiation that may cause harm to developing fetuses, so, before the examination you should give information to the radiology technician or radiologist if you are or may be pregnant.
Your doctor has evaluated the risk associated with this examination and believes that it is necessary for you and/or your child to have it performed. In such cases, the radiology technician takes care to apply the lowest possible dose and, if possible, takes measures to protect you and your baby.

**7. ATTENTION NEEDED PRE-EXAMINATION/POST-EXAMINATION:**

Please try to schedule your exam for a time when your breasts are least likely to be tender. If you haven't gone through menopause, that's usually during the week after your menstrual period. Your breasts are most likely to be tender the week before and the week during your period. Avoid using deodorants, antiperspirants, powders, lotions or perfumes under your arms or on your breasts. Metallic particles in powders and deodorants could be visible on your mammogram and cause confusion. After the examination, the patients can resume normal daily activities without any restrictions.

**Please fill in the following form.**

| | NO | YES | EXPLANATION |
|---|---|---|---|
| **Did you have mammogram before? What's the date?** | | | |
| **Did you have a breast problem?** | | | |
| **Did you have an operation?** | | | |
| **Did you use contraceptive pill?** | | | |
| **Are you or do you think you may be pregnant?** | | | |

**PROPOSED SCOPE OF THE EXAMINATION AND APPROVAL**

- ✓ I was informed in detail verbally about the tests and examinations recommended by my doctor.
- ✓ I allow intervention in unexpected and emergency situations.
- ✓ I have received information about the proposed average cost of the examination.
- ✓ I allow for my images to be archived digitally, to be sent to medical institutions abroad to be consulted and agree to the use of it in necessary scientific studies. I understand that this examination provides the opportunity to compare my previous and subsequent examinations and I understand that it avoids unnecessary tests again.

I ....., have understood the content of this form and I accept the examination to be performed at the Near East University Hospital with full awareness.
Signature: Date: Time:

**Approval from the patient's legal representative; Legal Representative Relationship:**
☐Patient unconscious ☐Under 18 years of age ☐Unable to make decision ☐ Emergency

**Witness (if one is present except hospital staff);**
Name – Surname: Signature: Date:
Time:

**Physician responsible;**
Name – Surname: Signature: Date:
Time:

**Translator (if necessary);**
Name – Surname: Signature: Date:
Time:

Consent is obtained

- In patients over 18 years of age, from the patients themselves.
- In patients aged between 15-18 years, from themselves and their legal representatives.
- In unconscious patients, under the age of 15, no decision-making ability, patient's medical and emergency from one of their legal representatives.