

APPENDIX R

IMPACT BIOPSY OPERATOR'S CHECK SHEET

Patient Name: _____

ID Number: _____

Patient Study Number (if known): -

Date of Birth: - -
Day Month Year

CORES TAKEN (Please tick):

Please refer to the Processing and Reporting of Prostate Biopsies protocol for more details (Appendix H of the IMPACT study protocol).

LEFT

- 1. Left base
- 2. Left lateral base
- 3. Left mid-lateral
- 4. Left mid-sagittal
- 5. Left apex
- 6. Left mid zone periphery (FOR RESEARCH)*

RIGHT

- 1. Right base
- 2. Right lateral base
- 3. Right mid-lateral
- 4. Right mid-sagittal
- 5. Right apex
- 6. Right mid-zone periphery (FOR RESEARCH)*

* These are suggested sites of biopsy. If there is an area of ultrasound abnormality, please take additional research cores in this area. If this area is large enough, both research cores can be taken from this area.

PROSTATE DIMENSIONS/ cm

Anterior to posterior cm

Left to right cm

Apex to base cm

,
.