CYSTOSCOPY

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS.

The following has been explained to me in general terms and I understand that:

1) The diagnosis requiring this procedure is: _____

_____.

2) The nature of the procedure is to insert a lighted telescope into the bladder.

3) The purpose of the procedure is to inspect the lining of the bladder, urethra and (in men) the prostate.

4) This procedure is usually performed with local anesthetic. However in the event of IV Conscious Sedation We must inform you of the risks. **MATERIAL RISK OF THIS PROCEDURE AND IV CONSCIOUS SEDATION** IV Conscious Sedation includes intravenous and intramuscular administration of agents to produce the desired effect. Selection of the type of anesthesia is based on the proposed operation. Sedation is attained without total loss of consciousness, so some awareness during the procedure is normal. As result of this procedure being performed, there may be material risks of : INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, INJURY TO OR MISCARRIAGE OF UNBORN CHILD, LOSS OF OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH. Other less serious risks of IV Conscious Sedation include but are not limited to injury to teeth, bridges, etc., nerve injury to extremities and pneumonia related to vomiting and aspiration.

5) In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to: perforation of the bladder or urethra, scar tissue in the urethra, blood in urine, urinary retention (inability to urinate).

6) The likelihood of success of the above procedure(s) is:
( ) Good ( ) Fair ( ) Poor

7) Practical alternatives to this procedure include: _____

_____

8) If I choose not to have the above procedure, my prognosis (future medical condition) is: _____

_____

_____

_____ (Place Check Mark if patient undergoing instillation of Dimethyl Sulfoxide [DMSO]) I understand that this substance is instilled as a treatment for interstitial cystitis and that, after the instillation, I may have some burning and/or irritation. I understand adverse reactions include: allergic reaction. _____ ***(Patient Initial)***

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above, it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedure described herein.

I also consent that any tissues (biopsies), specimens, organs or limbs removed from the patient's body in the course of the procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAVE HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN.

I understand the information above and I hereby voluntarily request and consent to the performance of the procedure described or referred to herein by Dr. _____ and any other physicians or other medical personnel who may be involved in the course of my treatment.

_____ _____

Witness Person giving consent Date/Time

_____ _____ _____

Date Time Person giving consent (Print Name)

Relationship to patient if not the patient:_____

Patient unable to sign because _____

_____