Direct visualization of the urinary tract with lighted instruments is referred to as a Cystoscopy. Your physician has advised you of your need to have this type of examination. The following information is present to help you understand the reasons for, and possible risks of, these procedures.

At the time of your examination, the inside lining of the urinary tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) will be removed for microscopic study, or the lining may be brushed and washed with a solution that can be sent for analysis of abnormal cells (cytology). Small growths can frequently be completely removed. Occasionally, during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilation).

The following are the principal risks for these procedures:

(1) Injury to the lining of the urinary tract by instruments that may result in perforation of the wall and leakage into body cavities.
(2) Bleeding, if it occurs, usually is a complication of a biopsy or dilation. Management of this complication may consist only in careful observation or possibly a surgical operation for control.

Other risks include drug reactions and complications incidental to other diseases you may have. You should inform your physician of all your allergic tendencies and medical problems. All of these complications are possible, but occur with a very low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for cystoscopy.

A brief description of each procedure follows. Either flexible or rigid instruments may be used.

Checked procedures will be performed for you today by Dr._____

- ☐ Cystoscopy with possible Urethral Dilation
- ☐ Cystoscopy with possible Urethral Dilation, Biopsy or Fulguration
- ☐ Cystoscopy with possible Urethral Dilation, Biopsy or Fulguration with Hydro-dilation of Bladder
- ☐ Cystoscopy with possible Urethral Dilation with Retrograde Pyelogram, _____ side
- ☐ Cystoscopy with possible Urethral Dilation, Stent Placement or removal with possible replacement, _____ side
- ☐ Cystoscopy with possible Urethral Dilation, Ureteroscopy, possible Retrograde Pyelogram, possible Laser Lithotripsy of a stone, possible placement/replacement of a Stent, and possible Dilation of the Ureters, _____ side
- ☐ Cystoscopy with possible Urethral Dilation, Trans-Urethral Resection of a Bladder Tumor and/or Bladder Neck Contracture
- ☐ Cystoscopy with possible Urethral Dilation, Trans-Urethral Resection of the Prostate
- ☐ Trans-rectal Ultrasound of the Prostate with Needle Biopsy
- ☐ Extra Corporal Shock Wave Lithotripsy, _____ side
- ☐ Holmium Laser
- ☐ Other_____

The physician performing these procedures has provided the above information to me. I certify that I understand the information regarding the procedure, and that I have been fully informed of the indications for and alternatives to the procedure, and the risks and possible complications thereof. I consent to the taking and reproduction of any photographs in the course of this procedure for professional purposes. I consent to the administration and maintenance of anesthesia, as considered necessary or advisable by the professional responsible for such services. I hereby authorize and permit my physician and Pacific Endo-Surgical Center and whomever my physician may designate as assistant to perform upon me the procedure(s) indicated above. If any unforeseen condition arises during this procedure or medication (including anesthesia), at a time when I am unable to consent, I further request and authorize the above named physician to use such reasonable measures, including transfer to a hospital, as my condition may warrant until I am able to provide further consent and authorization. I also understand that one or more of the physicians providing my treatment may have an ownership in this facility. I understand that my medical record may be used in the quality improvement practices of the center, always maintaining my privacy and anonymity.

I certify that I have read and fully understand the above consent statement, that the explanations herein referred to are understood by me, that all my questions have been answered, that all blanks or statements requiring insertion or completion were filled in prior to the time of my signature, and that this consent is given freely, voluntarily and without reservation and I understand that if I am receiving anesthesia, I am required to have a companion accompany me to the Center and be available during and after my surgery and that I will be discharged to that person's custody and must rely on him or her for my return home. I understand that I have the right to refuse any medical and surgical procedures and treatment. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure. I am also aware that no diagnostic exam is 100 per cent accurate, and there is a chance of a missed diagnosis during my procedure.

Date_____ Time_____ AM PM

_____
Physician's Signature

_____
Patient/Other Legally Responsible Person's Signature

_____
Relationship of Legally Responsible Person to Patient

_____
Witness Signature

PACIFIC ENDO-SURGICAL CENTER

AUTHORIZATION FOR UROLOGY