

Company Name

Name: Fname Lname
Chart #: /SharedID
DOB: /DOB
Age: /Age
Date: /Today
Referring Physician: /RP

CONSENT FOR CYSTOCOPY

Dr. _____ has told me that I have the condition(s) circled below:

Hematuria Incontinence UTI SUI FB Hx TCCB BOO Other _____

This condition needs to be treated for the reason(s) circled below:

R/O Stones – Tumors R/O Recurrence Removal FB

The doctor has recommended the procedure(s) circled below:

Cystoscopy UD Cystoscopy Stent Removal

The doctor has explained to me the following facts regarding the recommended procedure(s)

- | | |
|---|----------------------------------|
| 1. The procedure generally consists of: | Looking into the bladder |
| 2. The procedure has the following risks: | Bleeding and/or infection |
| 3. Alternative treatment for my condition are as follows
(Not recommended by the doctor at this time): | None |
| 4. There is no guarantee that this procedure will improve my condition. | |

I understand the reasons and risks of having the recommended procedure(s) and authorize this doctor and such other doctors or persons that are needed to assist him to perform this procedure on me.

Patient Signature: _____ Date: _____ Time: _____

Witness Name: _____

Witness Signature: _____ Date: _____ Time: _____

I DECLARE THAT I HAVE PERSONALLY EXPLAINED THE ABOVE FACTS TO THE PATIENT OR TO THE PATIENT'S AUTHORIZED REPRESENTATIVE.

Doctor Signature: _____ Date: _____ Time: _____