Company Name

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

CYSTOSCOPY OFFICE PROCEDURE

INDICATION ( ) Hematuria ( ) Hx B.T. ( ) SUI ( ) FB

( ) Recurrent UTI ( ) Incontinence ( ) BOO

( ) Other _____

UD _____

Ant Urethra ( ) WNL

Prost Urethra ( ) OPEN ( ) Visually Obstructed

Bladder Mucosa ( ) No lesion ( ) No Diverticuli

Uretheral Orifices ( ) Slit Like ( ) Clear

IMPRESSIONS ( ) BOO ( ) Negative Hematuria W/U ( ) SUI

PLAN ( ) Flomax 0.4 mg QD ( ) Cardura 1mg/day x 3 then 2 mg

Copy to Doctor: _____

_____ Doctor Name MD

_____ Doctor Name MD

_____ Doctor Name MD