



Affix Patient Label

Patient Name:

DOB:

Informed Consent Cystoscopy, Cystoscopy with Biopsy, or Cystoscopy with Removal of Stent

This information is given to you so that you can make an informed decision about having a **Cystoscopy, Cystoscopy with Biopsy, or Cystoscopy with Removal of Stent**.

Reason and Purpose of the Procedure

Cystoscopy is the placement of a small telescope into the bladder by guiding the scope down the urethra (the tube through which you urinate). The scope allows the doctor to see inside the urethra and bladder, and possibly diagnose any problems. This procedure takes just a few minutes. It can often be done using only numbing jelly to reduce discomfort. Fulguration (burning) of the biopsy site may be done to stop bleeding.

Your doctor can take biopsies (small samples) of the area through the scope. The doctor can also remove a stent if it has been placed for a kidney stone.

Benefits of this procedure

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

Your doctor may be able to find the cause of many urinary conditions, including:

- Frequent urinary tract infections.
- Hematuria or blood in the urine.
- Frequent and urgent need to urinate.
- Unusual cells found in a urine sample.
- Painful urination, chronic pelvic pain, or painful bladder.
- Urinary blockage caused by prostate enlargement or other abnormality of the urinary tract.
- A stone in the urinary tract, such as a kidney stone.
- An unusual growth, polyp, tumor or cancer in the urinary tract.

Risks of Surgery

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of surgery

- **Small areas of the lungs may collapse.** This would increase the risk of infection. This may need antibiotics and breathing treatments
- **Clots may form in the legs, with pain and swelling.** These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal
- **A strain on the heart or a stroke may occur**
- **Bleeding may occur.** If bleeding is excessive, you may need a transfusion
- **Reaction to the anesthetic may occur.** The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you

Risks of this procedure

- **Bleeding:** Bleeding may darken the urine color. This usually clears over a few days. Blood clots may block the bladder. A catheter may need to be inserted to flush out the clots. If bleeding continues, you may need more surgery.
- **Inability to Pass the Scope:** A scar or stricture (closure) may prevent the passage of the scope into the bladder. This may need surgery.
- **Inability to Remove a Stent:** If the stent has been in place for a long time, or stones have stuck to the stent, it may not be easy to remove it in the office. This may need more surgery.
- **Pain:** You may have pain or a burning feeling when you urinate for a few days after the procedure.
- **Perforation:** If the bladder is punctured it may need more treatment or surgery.
- **Urinary Retention:** In men, pressure from the scope can cause swelling of the prostate. This may block the flow of urine and cause retention (unable to urinate). This is more common with a history of an enlarged prostate. A catheter may need to be placed. Medicines or more surgery may be needed.
- **Urinary Tract Infection or Urosepsis (Bloodstream Infection):** Bacteria may get into the bladder or the bloodstream. More treatment with antibiotics may be needed.

Risks associated with smoking

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

Alternative Treatments

- Do nothing. You can decide not to have the procedure.
- You can talk with your doctor about other treatments.

If you choose not to have this treatment

- Your symptoms may not be diagnosed.
- Cancers may not be found.

General Information:

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Medical Implants/Explants:

- I agree to the release of my social security number, my name and address, and my date of birth to the company that makes the medical device that is put in or removed during this procedure. Federal laws and rules require this. The company will use this information to locate me, if needed.

Patient Name: _____

DOB: _____

By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Cystoscopy, Cystoscopy with Biopsy, or Cystoscopy with Removal of Stent (Circle or write specific procedure here)** _____.
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____ Date _____ Time _____

*Interpreter (if applicable)***For Provider Use ONLY:**

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date: _____ Time: _____

(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____