BRONSON

Affix Patient Label

Name_____ Date of Birth_____

Informed Consent:

BLADDER INSTILLATION

This information is given to you so that you can make an informed decision about having a **Bladder Instillation.**

Reason and Purpose of the Procedure:

During a bladder instillation, the bladder is filled with a therapeutic solution that flows in through a narrow tube inserted through the urethra and into the bladder, called a catheter. The instillation is held for varying periods of time. It then drained or voided.

The purpose of the instillation varies, depending on what is instilled. Some solutions are thought to coat and protect the bladder. Others are thought to suppress inflammation. This is also done to treat infections. Sometime a combination of ingredients may work better than a single agent.

It is important for you to discuss with your provider what medications will be used, and to check for any allergies.
Some common medications include:

Heparin: Heparin is a blood thinner that is used through bladder instillation to fight inflammation.
Lidocaine: Helps relieve pain
Sodium Bicarbonate: Helps neutralize the urine. This makes the urine less acidic to help relieve pain.
DMSO (dimethyl sulfoxide): Helps relieve pain
Gentamicin: To treat chronic urinary tract infections

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.

- **Decreased bladder and/or pelvic pain or pressure**
- **Decrease recurrent urinary tract infections**
- **Decreased urinary frequency**

Risks of Procedure:

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 a procedure done under general anesthesia:

- 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.

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- 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.
- You will not be allowed to drive or drink alcohol for 12 hours after the procedure if done under general anesthesia.

Risks of This Procedure:

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

- **Pain on catheterization:** This is usually brief.
- **Allergic reaction:** You may need medication to treat**.**
- **Urinary tract infection:** You may need antibiotics
- **Blood in the urine:** This usually resolves within 24 hours.
- **Difficulty urinating:** You may need to return to office for a catheter.
- **Lightheaded or sleepy:** If you feel lightheaded, notify your provider.

Added Risks Specific to DMSO Instillation:

- **Increased risk of developing cataracts:** It is recommended that patients have "slit-lamp eye examinations" before and after treatment to verify that no eye lens opacity (clouding) has occurred with treatment.
- **Garlic taste and odor to breath:** This can occur a few hours after instillation and continue for about a day
- **Pain on instillation:** About 10% of patients report bladder spasms and irritability. Your provider can discuss pain treatment options with you.

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:

_____

_____

_____

_____

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Alternative Treatments:

Other choices; your provider can discuss these further options with you:

- Do nothing. You can decide not to have the procedure
- Follow a strict diet prescribed by your doctor
- Oral medications
- Hydro distention of the bladder
- Vaginal electrical stimulation
- Intravenous antibiotics for recurrent urinary tract infections

If you choose not to have this treatment:

- **You may continue to have bladder and/or pelvic pain or pressure**
- **Recurrent urinary tract infections**
- **Increased urinary frequency may continue or worsen**

General Information

During this procedure, the provider may need to perform more or different procedures than I agreed to.

During the procedure the provider may need to do more tests or treatment.

Students, technical sales people and other staff may be present during the procedure. My provider will supervise them.

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.

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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: **Bladder Instillation**
- _____.
- 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 procedure. 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 the procedure. If so, please obtain consent for blood/products.

Patient Signature _____

Relationship ☐ Patient ☐ Closest relative (relationship) ☐ Guardian

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 the procedure

Provider Signature:_____Date:_____Time:_____

Teach Back

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:_____
_____
____ Side effects of the procedure:_____
____ Alternative(s) to the procedure: _____
_____

or
____ Patient elects not to proceed: _____ (patient signature)

Validated/Witness:_____ Date:_____ Time:_____