BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Informed Consent

Percutaneous Tibial Nerve Stimulation (PTNS).

This information is given to you so that you can make an informed decision about **Percutaneous Tibial Nerve Stimulation (PTNS).**

Reason and Purpose of the Procedure:

PTNS is a treatment for overactive bladder. It is for the symptoms of urinary urgency, frequency and incontinence (unable to hold your urine).

A slim needle electrode is inserted near the ankle. It is connected to a battery-powered stimulator. The impulses from the stimulator travel through the tibial nerve to the sacral nerve plexus. These are the nerves that control bladder function. Studies show that stimulating this nerve can sometimes decrease the symptoms of an overactive bladder.

The treatment lasts about 30 minutes. There are usually 12 treatments scheduled a week apart. If this works well you may need refresher treatments once a month to keep the results. Your doctor will discuss this with you.

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.

- A decrease in urinary urgency.
- Decrease in urinary frequency.
- Decrease in incontinence.

You should not have this procedure if you:

- **Have a pacemaker or implantable defibrillator.**
- **Have had problems with bleeding**
- **Have nerve damage that may impact the tibial nerve or pelvic floor.**
- **Are a woman who is pregnant or planning to become pregnant during the treatments.**

Risks of Procedures:

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.

Risks of this Procedure:

- **Pain or discomfort at the stimulation site**. Your doctor can discuss pain medicine with you.
- **Redness or inflammation at or near site.** This is usually temporary. If signs and symptoms of an infection are present, you may need antibiotics.
- **Bleeding at the site.** This is usually easily controlled.
- **Toe numbness**. This is usually temporary.
- **Stomach ache**. This is usually temporary.

BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

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:

Other choice:

- Do nothing. You can decide not to have the procedure.
- Your provider can discuss other options with you.

If You Choose Not to Have this Treatment:

- Your bladder issues may not be controlled.
- You may need medication, surgery or other treatments instead.

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.

BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

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 **Percutaneous Tibial Nerve Stimulation (PTNS)**:_____
- 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 procedure. 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 provider'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

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: _____ (patient signature**)**

Validated/Witness:_____Date:_____Time:_____