ADVANTIA HEALTH

In Office Cystoscopy Consent

Virginia state law guarantees that you have both the right and obligation to make decisions concerning your health care. Your doctor can provide you with the necessary information, but as a member of your personal health care team, you must help make the decision. This form has been designed to show that you agree with the surgery/procedure and treatment recommended by your doctor.

Details of Procedure:
Cystoscopy: A diagnostic procedure to visualize the interior surface of the urethra and bladder. A topical anesthetic (Lidocaine) will be inserted into the urethra if not allergic prior to the procedure. A small camera will be inserted in the urethra and advanced into the bladder to visualize the lower urinary tract. A biopsy to obtain a small sample may be obtained to send out for pathology if indicated. You may feel slight pressure or discomfort. The doctor may or may not take pictures. Based on the findings, additional testing or procedures may be ordered by your doctor. The procedure lasts about 5-10 minutes.

Side Effects of Procedure:
After the procedure, you may feel burning with urination, have pink-tined urine, and feel like you need to urinate more frequently. If you have bright red blood, develop a fever of 100.5 degrees F, have chills or pass blood clots please call the doctor. There may be other unknown risks associated with this procedure.

Post Procedure:
It is important to drink plenty of non-caffeinated fluids. To relieve minor discomfort, try a heating pad and Tylenol or Advil.

Benefits of Procedure:
The procedure is performed to evaluate and/or rule out any abnormalities of the bladder and urethra.

Risks:

Infection	Pain	Worsening and/or recurrence of symptoms
Bleeding/Hematoma	Injury to tissue	Allergic Reaction

Patient Responsibilities:
Disclose any allergies to Lidocaine or Betadine.

Patient Consent:
I am legally competent and have sufficient knowledge to give this voluntary and informed consent. I have read and fully understand the consent form.

_____ _____ _____
Patient Signature/Health Surrogate Relationship Date

_____
Witness Signature

Physician certification: I HEREBY CERTIFY that I have provided and explained the information set forth herein and answered all questions of the Patient or the Patient's Representative, concerning the Medical Treatment or Surgical Procedure to the best of my knowledge and ability.

_____ _____
Signature of Physician Date/Time

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