

# CYSTOSCOPY CONSENT FORM

I, \_\_\_\_\_, hereby authorize {name of Provider}, and/or his assistant to perform the below listed procedure. The risks and benefits have been explained to me by the doctor and/or their assistant to my satisfaction. I also understand that the doctor makes no guarantee as to the success of this procedure in delineating and/or diagnosing the condition that I presented with. In some cases, these procedures will need to be repeated, possibly under anesthesia on an outpatient basis.

CYSTOSCOPY is performed to survey the urethra, prostate, and/or bladder to search for the causes of urinary obstruction, incontinence, bleeding, and/or irritative urinary symptoms. This involves putting an endoscope through the urethra. The risks of this procedure include, but aren't limited to, worsening of your obstruction or irritative voiding symptoms, bleeding (potentially requiring more aggressive interventional procedures), painful urination, bladder or urethral perforation, and infections (potentially requiring hospitalization).

I understand that I will be given adequate and appropriate post procedure instruction and will do my best to comply with them along with following up at the appropriate post-procedure interval. I know to call the doctor immediately for any of the side effects mentioned above, especially high fever, profuse bleeding, and/or pain.

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Patient signature

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Date

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Witness