First Hill
SURGERY CENTER

1101 Madison St., Suite 200 • Seattle, WA 98104-1306

Extracorporeal Shock Wave Lithotripsy and Stent Placement

# Consent Form

Patient's Name: _____ Date of birth: _____

*Last, First, MI*

Guardian Name (if applicable): _____ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

## 1. MY PROCEDURE

I hereby give my consent for Dr. _____ and associates to perform a ☐right ☐left ☐bilateral extracorporeal shock wave lithotripsy ☐with ☐without stent placement.

upon me. I understand the procedure is to be performed at the First Hill Surgery Center. This has been recommended to me by my physician in order to diagnose and/or treat kidney or ureteral stones.

## 2. MY BENEFITS

**Some potential benefits of this procedure include:** elimination of urinary tract stone(s) and to re-establish the flow of urine to the kidney to the bladder and discourage the formation of stones.

## 3. MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure including: Urinary tract infection or urosepsis, ureteral blood clots, hematoma, loss of kidney function, chronic pain, blockage of ureter by stone fragments, urinary retention, uretral injury, inability to place stent requiring alternative procedure. Risks of hypertension and diabetes remain debatable in the literature. Some stones do not break up entirely or at all and may require either repeat or alternative treatments. Stents can obstruct and cause pain. Stents rarely get dislodged.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

## 4. TISSUE DISPOSAL/PATHOLOGY

Any tissue or specimen may be disposed of in accordance with accustomed practice; or specimen sent to pathology for evaluation in agreement with my designated healthcare provider.

***continued on next page.***

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## 5. MY CONSENT

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment for my condition including no treatment** or other procedures or tests such as cytology or diagnostic imaging. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed procedure(s) listed above and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.
I consent to the above procedure(s) as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ Date: _____ Time: _____

Patient is unable to consent because _____ . I therefore consent for the patient.

Authorized Consenter's Signature: _____ Date: _____ Time: _____

Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____