First Hill
SURGERY CENTER

Prostate Cryoablation (Cryotherapy) Consent Form

Patient Name: ______________________ Date of Birth: _____

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.________________________________an associates to perform a prostate cryoablation (cryotherapy) upon me. I understand the procedure is to be performed at The Polyclinic Urology Department this has been recommended to me by my physician in order to diagnose and/or treat prostate cancer.

2 MY BENEFITS

Some potential benefits of this procedure include:

cure prostate cancer, prevent progression of prostate cancer

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

incontinence, erectile dysfunction (likely), urinary retention, scrotal edema, perineal numbness, scar tissue, bleeding and infection, cancer recurrence, penile shrinkage.

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.

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____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 procedures 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: _____