First Hill
SURGERY CENTER

GreenLight Photo Vaporization of the Prostate (PVP)
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._____to perform a **Greenlight Photo Vaporization of the Prostate** upon me. I understand the procedure is to be performed at First Hill Surgery Center. This has been recommended to me by my physician in order to diagnose and/or treat urinary obstruction and/or bleeding**.**

I understand that the procedure or treatment can be described as follows:
Inserting a scope into the urethra and using a laser to remove obstructive prostate tissue.

This procedure may require general or spinal anesthesia which will be administered by a qualified anesthesiologist. Your anesthesiologist will be available to discuss this further with you on the day of your procedure.

2 MY BENEFITS

Some potential benefits of this procedure include:

- Improved urinary symptoms

3 MY RISKS

I understand that there are **potential risks, complications and side effects** associated with any surgical 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.

These could include but may not be limited to the following:

- Hematuria – When using the laser on prostate tissue, small blood vessels (arteries and veins) may be cut and bleed. Throughout the entire procedure, the vessels are cauterized (burn) shut. At the end of the procedure, the area is carefully inspected to ensure that there is no significant bleeding. Sometimes the catheter is manipulated to compress the vessel. In patients with continuous irrigation, the rate of irrigation dripping can be increased to clear the urine. If clots form, the catheter can block and hand-irrigation will be required to remove the clots. Rarely, is returning to the operating room required to recauterize the clots in bladder. If bleeding is prolonged, you blood count will be checked. It is rare to need a blood transfusion after a PVP.
- It is not uncommon to see blood in the urine for up to 2 weeks after surgery and may clear temporarily and rebleed days or weeks later. Usually there is no risk to health unless clots form and obstruct passage of urine.
- On rare occasions, if a catheter is in place when returning home, clots may obstruct the flow. If you feel distended and urine flow stops into the catheter, go to the nearest emergency to have the clots removed.

- *Urinary tract infection or Urosepsis (bloodstream infection).* Even with a minor and sterile procedure it is possible to get an infection with bacteria that typically cause urinary tract infections (UTIs). The symptoms of a bladder infection are burning urination, urinary frequency and a strong urge to urinate. UTIs usually resolve with a few days of antibiotics. If the infection enters the bloodstream, this type of infection will most likely present with urinary symptoms and any combination of the following: fever, shaking chills, weakness or dizziness, nausea and vomiting. Hospitalization with intravenous antibiotics, fluids, and observation may be required. Diabetics, patients on long-term steroids, patients currently with indwelling catheters, or with immune system disorders are most likely to have these complications. **If you develop a high temperature or severe illness symptoms (fevers, shaking chills, weakness or dizziness, nausea or vomiting, confusion) let your doctor know and proceed to the nearest emergency room immediately.**
- Urethral Stricture/Bladder Neck Contracture – A stricture is scar tissue that can form anywhere in the urethra following prolonged instrumentation. It typically occurs weeks to moths (or even longer) after the procedure. Scar tissue can also form at the exit (neck) of the bladder, and this is termed a contracture. For either condition, another scope procedure may be necessary to open the scar.
- PSA – your PSA will generally go down by about 35% after the procedure
- Retrograde ejaculation – between 30-80% of men will no longer have forward ejaculation. This is not a health problem but may cause infertility or cosmetic concern.
- Urinary incontinence
- Urinary Retention
- Perforation–
- Damage to the Ureters
- Erectile Dysfunction
- Failure to resolve the condition
- Deep Vein Thrombois (DVT) /Pumonary Embolus (PE)
- Dysuria – Pain with urination. Immediately after the surgery there could be pain with urination. This typically resolves in a few days and is usually mild. Rarely, patients complain of dysuria or pain with ejaculation for several months.

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 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. In many cases, this surgery is elective, meaning not essential to your health. It is for improvement of quality of life. Alternatives to this procedure may include, but are not limited to medication, catheterization, alternative surgery such as TURP and use of other types of lasers. 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 **GreenLight Photo Vaporization of the Prostate (PVP)** 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:** _____