First Hill
SURGERY CENTER

Hydrodistention of the Bladder
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 **Bladder biopsy and Hydrodistension** 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 interstitial cystitis (IC).

I understand that the procedure or treatment can be described as follows:
Procedure is performed on an outpatient basis and typically takes about 30 minutes. You will be placed lying down on your back with your legs gently elevated in stirrups. A cystoscope will be inserted through the urethra and into the bladder so that the bladder may be fully examined. Fluid is then run through the scope until the bladder is distended to a specific calculated pressure and then drained after a certain period of time. After drainage, the bladder is slowly filled again to look for specific abnormalities and to take one or more biopsies if needed. The bladder is then emptied once more and the scope removed. Tissue samples may be obtained from the superficial lining of the bladder with the scope and then cauterized to stop bleeding.

This procedure requires either 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:

- Confirmed diagnosis of IC, relief of pelvic pain, urinary frequency, nocturia and urgency

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, urinary tract infection, urosepsis, urinary retention, and/or perforation

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 oral medication, bladder instillation of therapeutics, or alternative therapies. 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 **hydrodistention of the bladder and biopsy of bladder** 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: _____