First Hill
SURGERY CENTER

Prostate Brachytherapy
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 _____ to perform **Prostate Brachytherapy** 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 cure my prostate cancer.

I understand that the procedure or treatment can be described as follows:
Brachytherapy (more commonly known as "seed-implantation") is a procedure in which a small radioactive seeds are placed in the prostate to kill prostate cancer cells. It is a procedure in which both a urologist and a radiation oncologist (doctor who specializes in radiation treatment for cancer) may be involved. Seed implantation does not require a skin incision because the seeds placed through small needles in the perineum (area behind the scrotum and in front of the anal region).

You will be in lithotomy position (on your back with your legs in stirrups much like the position for an exam at the gynecologist). The type of anesthesia used will reflect the suggestion of the anesthesiologist as well as contributions from your preferences as well as your surgeon.

A catheter is placed into your urethra and into your bladder. The bladder may be filled with a contrast dye so that we can see the outline of your bladder using X-ray. An ultrasound probe s placed in the rectum just like the one placed during your original prostate biopsy. A special needle guise is then placed against the perineum (area of your body between your scrotal sac and anal region). Using a combination of X-ray and ultrasound guidance (or ultrasound alone) the needles are carefully placed through the skin and into very specific areas of the prostate. These needles are hollow, and the seeds are placed into the prostate when pushed through using a special instrument. The placement of seeds will correspond to a "dosimetry plan." This is a sophisticated computerized program used to determine how the dose of radiation should be distributed in your individual prostate gland. We are able to confirm the position of the seeds using ultrasound and possibly X-ray as well.

After all the seeds are placed, the catheter s removed. We may the place a cystoscope (small telescope) into the bladder and perform an examination. We check for abnormalities of the bladder or urethra, and that no seeds migrated into the bladder itself. At this point, the procedure is over.

This procedure may require 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:

- Cure the patient of prostate cancer.

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:

- Loss of blood, heart attack, arrhythmia, adverse drug reaction, cardiac arrest, death, stroke pneumonia, deep vein thrombosis, pulmonary embolus, burning with urination, urinary retention which might require catheterization.
- Incontinence (involuntary loss of urine)
- Impotence (erectile dysfunction)
- Urinary tract infection or urosepsis
- Deep vein thrombosis (DVT)/pulmonary embolus (PE)
- Bladder neck contracture/urethral stricture/urethral necrosis
- Hemorrhagic cystitis (radiation cystitis)
- Wound infection
- Fistula formation
- Chronic pain

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.

I understand these special risks of this procedure and that these can be affected by obesity, diabetes, smoking, other factors.

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. Alternatives to this procedure may include, but are not limited to observation with regular PSA's and rectal exams. 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 **Prostate Brachytherapy** 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: _____