First Hill
SURGERY CENTER

Urethral Sling
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 **Urethral Sling** 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 _____.

I understand that the procedure or treatment can be described as follows:
Depending on your surgeon's preference, the entire procedure may be done through one to three incisions either in the vagina (for females) or in the perineum (for males). The incisions(s) is made for placement of the sling material around the bottom of the urethra. While not always necessary, a cystoscopy may be performed to ensure that everything is correctly positioned. The procedure typically takes 1-2 hours depending on the individuals' anatomy.

This procedure will 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:

- Relief from stress incontinence and improved quality of life.

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:

- Urinary tract infection or sepsis, wound infection, urinary retention, blood loss/transfusion, deep vein thrombosis, pulmonary embolus, sling erosion, bleeding/hematoma, lower extremity weakness/numbness.

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 the use of a pessary, urine seals or needle neck suspension. 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 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:** _____