טופס הסכמה: בדיקה אנדוסקופית של כיס השתן

CONSENT FORM: CYSTOSCOPY

A cystoscope is a firm or flexible telescopic instrument used to survey the urinary bladder and urethra through which various instruments and catheters can be passed to perform diagnostic and therapeutic procedures, such as: biopsies, excision of tumors, removal of stones and blood clots, and others. In addition, various catheters can be passed through the cystoscope for diagnostic and therapeutic procedures of the ureters and kidneys. The instrument is inserted through the urethra, usually under local anesthesia, and when the need arises, regional or general anesthesia, in men, and in most cases, without anesthesia in women.

The procedure is performed with the patient lying supine or on his/her back, with the legs raised, spread apart and bent, and supported by stirrups.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I have been given a detailed oral explanation by:
Dr. _____ _____
Last Name First Name
regarding the need for a **diagnostic and/or therapeutic*** cystoscopy. Detail planned treatment options:
_____
_____ (henceforth: "the primary procedure").

I hereby declare and confirm that I have been given an explanation concerning the side effects of the primary procedure, including: pain, discomfort, burning sensation during urination, frequent urination, and bloody urine. These effects are temporary and usually subside within 24 hours.

I have been given an explanation and understand the possibility that during the primary procedure, when diagnostic, the need may arise to perform therapeutic procedures, such as: biopsies from a tumor, cauterization of small hemorrhages or areas suspected to be tumors, and dilation of the urethra if narrowed.

In addition, it may be necessary to insert various catheters for additional diagnostic and therapeutic procedures.

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Moreover, I have been given an explanation concerning possible complications, including: urinary and/or genital tract infections accompanied by fever, chills and bleeding, which will necessitate hospitalization. Additional complications, although rare, may include damage to the lower urinary tract, and even perforation and narrowing of the urethra, which will necessitate surgical repair under anesthesia.

I hereby give my consent to perform the primary procedure.

I also give my consent to perform local anesthesia, at the discretion of the physicians, after I was told of the possible complications of local anesthesia, including various degrees of allergic reactions to the anesthetic drugs.

If the decision is made to perform the primary procedure under regional and/or general anesthesia, I will be given an explanation regarding the anesthesia from an anesthesiologist.

I know and agree that the primary procedure and any other procedure will be performed by any designated surgeon, according to the institutional procedures and directives, and that there is no guarantee that it will be performed, fully or in part, by a specific person, as long as it is performed in keeping with the institution's standard degree of responsibility and in accordance with the law.

_____ _____ _____

Date Time Patient Signature

_____ _____

Name of Guardian (Relationship) Guardian Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I have given the patient / the patient's guardian* a detailed oral explanation of all the above-mentioned facts and considerations as required, and that he/she has signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

_____ _____ _____

Name of Physician Physician Signature License No.

* Cross out irrelevan