



STACY J. CHILDS, M.D., F.A.C.S.  
JAMIE VANOVEREN, D.O.

### CONSENT FOR CYSTOSCOPY

I hereby authorize the physicians of the Urology Clinic P.C, Jamie L. VanOveren D.O. and Stacy J. Childs M.D. and or such assistants as may be requested by said physician to perform cystoscopy for the purpose as previously explained to me.

I understand that this procedure involves looking into the bladder with a lighted telescope and may involve the introduction of other devices as deemed necessary in association with the procedure.

Potential risks associated with this procedure include but are not limited to the risk of infection of the bladder requiring the administration of further antibiotics, a burning sensation immediately following the procedure when voiding, slight bleeding, and the possible need for additional tests or procedures.

I accept the treatment recommendation of my physician. I acknowledge that no warranty of guarantee has been made as to the results of this procedure. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician. I further certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of this procedure, of the possible alternative treatment choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

The procedure as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent is thus given as noted by signature.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness: \_\_\_\_\_

Physician Signature: \_\_\_\_\_