Northern Litho
INCORPORATED
LITHOTRIPSY SERVICE

Consent for Extracorporeal Shockwave Lithotripsy (ESWL)

NAME: _____

SPECIFICALLY:_____

(1) **DESCRIPTION OF PROCEDURE.** My physician has explained to me that I have been diagnosed as having urinary stones. My physician has recommended that I undergo Extracorporeal Shockwave Lithotripsy (ESWL), which I understand to be a means of pulverizing urinary stones using focused sound waves so that the stones may pass spontaneously in my urine. I understand that ESWL will require sedation while shockwaves are passed through my body. I understand that intravenous fluids will be given to me during the procedure by placing a needle into one of my blood vessels. I understand that antibiotics, pain medications, and other medications may be given as required. I understand that I will be closely monitored throughout the procedure and that the Lithotripsy suite is equipped to provide for emergencies.

(2) **RISKS/POSSIBLE COMPLICATIONS.** I have been advised regarding the possible risks and consequences associated with this procedure, including (but not limited to) the following:

(a) ESWL commonly results in bruising to the skin and kidney region as a result of the shock wave. Research has not totally eliminated the possibility of long-term kidney damage, development of high blood pressure and damage to the bowel or lung (as the lie close to the kidney.) Blood in the urine is common; however, urinary bleeding serious enough to require transfusion or surgical repair or removal of the kidney is rare.

(b) I understand that I may sustain ureteral colic (spasm of the ureter as the stone fragments pass from the kidney to the bladder) or urinary obstruction, which may require additional procedures or surgery for relief.

(c) I understand that, as a result of the treatment, I may sustain a urinary tract infection or an infection of the blood system or tissue.

(d) I understand that the use of IV sedation and/or analgesia carries the risks of infection, irregular heartbeat, irregular blood pressure, heart attack and stroke.

(3) **ALTERNATIVES TO PROCEDURE.** I understand that, in addition to doing nothing, there are alternatives to the recommended procedure including surgical removal of stones. I have been advised of the possible risks and consequences of those alternatives as they compare to ESWL.

(4) **NO GUARANTEES GIVEN.** I acknowledge that no guarantees have been made concerning this procedure. I have been advised that if I desire a further or more detailed explanation concerning my diagnosis, recommended and alternative procedures, or possible risks and consequences, it will be given to me by my physician. However, I am satisfied with the explanation given me and authorize my physician and such assistants, as may be selected by him to perform the recommended procedure outlined above.

(5) **ADMINISTRATION OF DRUGS.** I authorize the medical staff of Northern Litho Inc. to administer such drugs and to perform such pathological studies as may be necessary or advisable.

(6) **PERSONS AUTHORIZED TO SIGN FOR PATIENT.** If this form is executed by another on the patient's behalf, the person signing certifies that he is authorized to consent on the patient's behalf, and, where the context requires, all references herein to "I," "me," or "my" refer to the patient rather than the one who signs for the patient.

(7) **COPY OF THE PATIENT'S BILL OF RIGHTS RECEIVED.**

_____	_____	___/___/___	_____:_____ AM – PM
Patient or Person Authorized to Consent for Patient	Witness	Date	Time

The above information has been explained to the patient or the patient's representative.

DATE: ____/____/____ TIME: ____:____AM-PM PHYSICIAN _____