Northwest Urology Clinic Inc.
1311 E. Division St
Mount Vernon, WA 98274-4134
(360) 424-7991

Patient: _____ Patient No: _____

Washington State law guarantees that you have both the right and obligation to make decisions concerning 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 enter the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1) I hereby authorize Dr. _____ and / or such associates or assistants as may be selected by said physician to treat the following condition(s) which has (have) been explained to me: (Explain the nature of the condition(s) in professional and lay language.)

_____

_____

_____

_____

2) The procedures planned for treatment of my condition(s) have been explained to me by my practitioner. I understand them to be: (Describe procedures to be performed in professional and lay language.)

TRANSURETHRAL MICROWAVE THERAPY OF THE PROSTATE

At: **NORTHWEST UROLOGY CLINIC, INC.**
(NAME OF HOSPITAL OR MEDICAL FACILITY)

3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those above set forth. **I therefore authorize my above named practitioner, and his or her assistants or designees, to perform such surgical or other procedures as are in the exercise of his, her or their professional judgment necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of **all conditions** that require treatment and are not known to my physician at the time the medical or surgical procedure is commenced.

4) **I have been informed that there are significant risks** such as severe loss of blood, infection and cardiac arrest that can lead to death or permanent or partial disability, which may be attendant to the performance of any procedure. **I acknowledge that no warranty or guarantee has been made to me as to result or cure.**

IMPORTANT: HAVE PATIENT SIGN FULL OR LIMITED DISCLOSURE BOX AND SIGNATURE LINE AT BOTTOM

Full Disclosure In Professional And Lay Language

I certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of the possible alternative forms of treatment; and the recognized serious possible risks, complications, and the anticipated benefits involved in the proposed treatment and in the alternative forms of treatment, including non-treatment.

_____
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN IF APPLICABLE

Limited Disclosure

I certify that my physician has explained to me that I have the right to have clearly described to me the nature and character of the proposed treatment; and the recognized serious possible risks, complications, and anticipated benefits involved in the proposed treatment, and in the alternative forms of treatment, including non-treatment.

I do not wish to have these risks and facts explained to me.

_____
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN IF APPLICABLE

Any sections below which do not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both physician and patient.

5) I consent to the administration of anesthesia by my attending physician, by an anesthesiologist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks of complications and serious possible damage to vital organs such as the brain, heart, lung, liver and kidney and that in some cases may result in paralysis, cardiac arrest and/or brain death from both known and unknown causes.

6) I consent to the use of transfusion of blood and blood products as deemed necessary.

7) Any tissues or parts surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

I, the practitioner, have explained the risks, benefits, and alternatives of the treatment to the patient. I have answered all questions, and the patient wishes to proceed.

_____ A.M. P.M.
PRACTITIONER DATE TIME

_____
WITNESS

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

_____
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGN

_____
RELATIONSHIP OF LEGALLY RESPONSIBLE PERSON TO PATIENT

OPERATE OR OTHER PROCEDURE