



BLADDER STONE CRUSHING SURGERY CONSENT FORM



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PATIENT'S Patient File

No:.....

Name, Surname :.....

Birthdate :.....

Sex :.....

Division :.....

Consent Date :.....

Dear patient / deputy legal representative;

You have the right to be informed on the medical, surgical and diagnosis related procedures about your/your patient's health status and recommended for you/your patient, and their alternatives, benefits, risks and even possible damages that could take place, and to refuse or to accept all or part of these, or to stop the procedures to be conducted in any phase.

This form, which we ask you to read and understand, has been prepared to inform you on determining whether you will give consent for the applications or not, and to obtain your permission, and not to frighten you or scare you away from these medical applications.

INFORMATION

PREDIAGNOSIS :.....

PLANNED TREATMENT / ESTIMATED DURATION:.....

INFORMATION ABOUT THE PROCEDURE

The surgery is carried out under general anaesthetic or local anaesthetic. Bladder stone is crushed using a power supply like pressured air or laser by inserting a telescope from urethra, and small fragments are removed. After the operation, a drain is placed inside operative field.

ALTERNATIVE TREATMENTS

POSSIBLE COMPLICATIONS REGARDING PROCEDURE

1-In rare cases, 1% damage in urethra may occur and urea may drain out of bladder. Pseudourethra may develop and therefore may lead to enuresis and, in long-term, stricture development.

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2- 1% Bladder perforation may occur as a result of bladder damage. Open operation may be needed.

3- Urinary retention may develop as a result of urinary flow retention. Treatment with catheter may be needed.

4- Infections, which are mixing with blood and arising from bladder and prostate that seen below 2%, and are rare but serious, may lead to septicemia. In this case, antibiotic treatment may be required.

5- 10-25% bleeding may take place and urine color may change. At times urine flow may be hindered.

6- A few days after the procedure, burning sensation and tingling during urination may take place.

Generally, this problem is solved easily.

7- Stone fractures may remain in bladder and may not pass naturally.

8- Wound site, lung infection, heart and AC complications have enhanced the risk of thrombosis development for overweight people.

9- Enhanced wound and heart and AC complications have enhanced the risk of thrombosis development for smokers.

INFORMATION ABOUT THE SUCCESS RATE

INFORMATION ABOUT THE POSSIBLE CONSEQUENCES IN CASE OF REFUSAL OF PROCEDURE

(IF MEDICINE USE IS PLANNED) INFORMATION ABOUT OF SPECIFIC MEDICINE AND ITS FEATURES

IMPORTANT LIFESTYLE SUGGESTIONS FOR PATIENT'S HEALTH

ACCESS TO MEDICAL ASSISTANCE ON THE SAME SUBJECT WHEN NECESSARY

According to health legislation, every individual has the freedom to choose hospital and physician. You can reach medical assistance in public or private health organizations about your disease within the scope of your Social Security. When necessary, you can contact our hospital 24 hours a day, or you can get medical assistance by contacting the doctor or another specialist who performed the surgery with the phone number **0090 (222) 335 0 335**. In case of emergency, it is possible for you to get medical assistance at a health care facility near you or via an emergency call center (112).



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PATIENT'S QUESTIONS (IF ANY)

CONSENT

I have been told all the results I might have had if I am not treated or if I refused the treatment, and, in respect of all the procedures to be performed while diagnosis and treatment, I have been explained plainly and explicitly that I may encounter with infection, blood coagulation in veins and lungs, bleeding, allergic reaction or oedema at or far from surgical area, epileptic seizure, temporary or permanent organ/system functioning failure, death, including anameia and meningitis.

We know the other risks may be side effects, such as hypokinesis in incision area, permanent scar, body deformation as a result of bone subtraction/addition, cerebral fluid leakage from surgical area or needle site, headache or long-term/chronic ache, temporary or permanent voice loss causing from vocal cord palsy, temporary or permanent function loss in organs such as face, brow, tooth, eye or hearing impairment, swallowing impairment and vision loss and loss of bladder and stool control, changes in personality, become disabled due to tissue or organ damage and occurrence of need to use medicine/hormones for a lifetime, short or long-term ache due to position during the operation, and narcotism; and hereby approve these mentioned risks.

I have read the above given information and have been informed by the undersigned doctor. I have been informed about the purpose, risks and complications of the medical or surgical intervention to be performed. I approve this process consciously, without further explanation and under no pressure I hereby authorize the person named with giving approval and being informed about my treatment if I lose my consciousness by some means or another and am not able to give approval during the operations related to my treatment.

.....(Please write "I acknowledge that I have read and understood above" in your handwriting)

PATIENT

Time:

Signature:

Date:.....

Name Surname (handwriting):.....

Patient's father/mother/legal representative*

Signature:



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Date / Time:

Name Surname (handwriting):.....

*The person whose name is mentioned in the last paragraph should sign.

I have made adequate and satisfactory explanation to aforementioned patient / patient relative about the disease, operation to be performed, the reason and benefits of the operation, necessary postoperative care and probable risks, type of anaesthesia to be applied, if necessary, and risks and complications regarding anaesthesia. The patient / patient relative has signed and approved this form with their own consent that they have been adequately informed on the operation.

DOCTOR

Date / Time:

Signature:

Name Surname:.....

IF THE PATIENT HAS SPEECH / LANGUAGE DIFFICULTIES:

I have interpreted the statements made by the doctor to the patient. In my opinion, the information I have interpreted is understood by the patient.

INTERPRETER'S:

Date / Time:

Signature:

Name Surname (handwriting):.....

You can consult with Patient Services Directorate during the day and the Night Chief during the nights for all your complaints or any other issues you wish to address about medical applications.

*Legal Representative: The guardian for those under guardianship, the parents for minors, in cases where they do not have one of these, first degree lawful heirs. Signing this consent form does not abolish the patient's legal rights.