MCSO
Metro Chicago Surgical Oncology, LLC

CONSENT FOR CYSTOSCOPY

Patient's Name and DOB:

_____

I understand that I have been scheduled for a Cystoscopy. I have been informed of the risk and complications that may occur during or after the procedure. I certify that my MCSO physician has informed me of the nature and character of the proposed treatment and of the anticipated results of the proposed treatment.

I acknowledge that any aspect or part that may be removed surgically will be sent for pathological evaluation or be disposed of by the office in accordance with custom practice.
I understand that any aspect of this consent that I do not understand can be explained to me in further detail by asking physician or staff.

You have both the right and obligation to make decisions concerning your health care. Your physician can provide you with necessary information and advice, but as a member of the healthcare team, you must enter into the decision process.

This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

Patient Signature: _____

Date: _____