Metro Chicago Surgical Oncology, LLC

Urology Practice Form of Consent

REZUM

1. I consent to having a procedure performed on me to treat enlarged prostate tissue associated with benign prostatic hyperplasia (BPH) secondary to lower urinary tract symptoms using the Rezūm System. A cystoscopic instrument with a camera lens will be inserted through my urethra and into my prostate to allow my doctor to evaluate the enlarged tissue causing the BPH and treat this prostate tissue using a small needle that will be deployed from the instrument. I may receive anesthesia, anesthetics, painkillers, or other medications prior to or during the procedure.

2. In giving my permission for this procedure, I acknowledge that my doctor has explained to me:

a. The procedure and the purpose for the procedure in terms that I understand.

b. The possible alternative methods of treating my BPH.

c. The possible (i) risks and complications which may occur during or after the procedure in terms that I understand, including the risks of not doing the procedure; (ii) transitory risks and complications of the procedure including, but not limited to, irritative or burning sensations during urination, bleeding, sensations of frequency or urgency to urinate, pain, or infection.

d. There are no guarantees about the results of the procedure or that the procedure will completely treat or eliminate the symptoms of my BPH condition.

e. Additional testing and/or other procedures may be recommended or needed at a later date with respect to my BPH condition.

3. It is my responsibility to ask my doctor and his/her associates any questions I may have about any aspect of this consent form that I do not understand.

4. I have the right to withdraw my consent at any time prior to the procedure.

5. This consent form has been explained to me and I have read it, or have had it read to me. I have been given the opportunity to ask questions about this consent form. This consent form has been designed to acknowledge my acceptance of treatment as recommended by my doctor or physician assistant.

6. I believe I have received sufficient information to give this informed consent.

Patient signature: _____ DOB: _____

Print Patient Name: _____Date: _____