Center for Sexual
& Urinary Function

**Patient Informed Consent: URETHRAL TAPE PROCEDURE**

**1. OPERATION FOR PROCEDURE AND ALTERNATIVES:**
I, _____, (patient or guardian) both authorize Peter Niemczyk, M.D. and assistance of his choosing to perform the following operation for procedure to support the urethra by placing a tape (using special synthetic known to create if material) under the urethra to compress the urethra during increases in the abdominal pressure. This is called **urethral tape placement.** I understand the reason for the procedure is **loss of urinary control** or incontinence. Alternatives include: observation, pessary, and other types of open surgical repair, diapers, or insertion of catheter.

**2. RISKS**: this authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some will be significant early risks of the procedure are **bladder injury requiring overnight catheterization, irritation, urgency or frequency of urination, retention of urine requiring prolonged catheterization (placement of catheter in the bladder) or the use of self-catheterization.** Late complications include **discomfort from pulling of the tape supporting the urethra, discomfort with sexual intercourse and the need to further reduced vaginal wall to prevent falling of the bladder at later time (cystocele repair), protrusion of the sling through the vaginal wall, urethral wall, and bladder wall at later stage and reaction to sling material (inflammation, infection or allergic) requiring removal of the sling.** I also understand that the more common risks of any procedure include: allergic reaction (especially when anesthetics are used), bleeding, infection, nerve injury, blood clots, trauma to tissues and/or surrounding structures, heart attack and pneumonia. These are serious and possibly fatal.

**3. ANESTHESIA:** the administration of anesthesia also involves serious risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for these services except: _____

**4. ADDITIONAL PROCEDURES:** if my physician discovers a different, unsuspected condition at the time of surgery, I also authorize him or her to perform such other procedures as deemed necessary except: _____

**5. RESULTS NOT GUARANTEED:** I understand that the no guaranteed or assurance has been made as to the result of the procedure and that it **may not cure the condition**.

**6. PATIENT'S CONSENT:** I have read the and a fully understand this consent form, and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. If you have any questions as to the risks, hazards, or alternatives of the proposed procedure, ask your physician before signing this form. Do not sign unless you have read and thoroughly understand this form!

_____ _____ AM
Patient/Responsible Party Date Time PM

_____
Witness

Physician declaration: I have explained the contents of this document to the patient and have answered all patient's questions, and to the best on my knowledge, the patient has been adequately informed. The patient has consented.

_____ _____ AM
Physician's Signature Date Time PM

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