NAU UROLOGY SPECIALISTS

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Patient Procedure/Treatment Consent Form
Shockwave

Patient Name:________________________ DOB: _______________________

I hereby authorize and direct _____________________________ and assistants, as necessary to perform quality care, to perform the following procedure/treatment on me:

✔ Shockwave

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

- Numbness or tingling at treatment site
- Petechial bruising (tiny bruising spots of pinpoint size in the skin)
- Injury to penis, urethra, or perineum
- Pain to penis, urethra, or perineum

Numbness, tingling, and bruising are the most common side effects, and typically resolve within 2-6 days after initial treatment.

I acknowledge that no guarantees have been made to me as to the outcome of procedure(s) and/or treatment(s). I grant this consent without duress, confusion, or pressure from my physician and/or staff, associates, or colleagues.

Patient/Representative Signature: _____________________________________

Date: _________

Witness Signature: ____

Date: _________