NAU UROLOGY SPECIALISTS

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Patient Procedure/Treatment Consent Form
Xiaflex Penile Injections

Patient Name:_____ DOB: _____

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

- ✔ Xiaflex Penile Injections

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:

- Pain
- Bleeding
- Inefficacy
- Infection
- Recurrence in curvature

The care provider has explained my condition to me, the above treatment procedure and alternative methods of treating my condition. As well as discusses with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the care provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which was not known previously. I consent to the administration of local, regional or general anesthesia and/or sedation as most appropriate for the above procedure. For procedures that have a potential for significant blood loss, I consent to the transfusion of blood or blood components as necessary.

I have carefully read and fully understand this informed Consent Form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been answered.

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: _____