Northwell Health Physician Partners | Westchester Health

Jerry Weinberg, MD
Westchester Health Urology
666 Lexington Avenue, Suite 100
Mt. Kisco, NY 10549

Patient Medical Record (write in or apply sticker)

Name: ______________________________________

Medical Record No. ____________________________

DOB: _______________________________________

Admitting MD: ________________________________

Cystoscopy Consent Form

I, ____________________________________, Date of Birth ______________, hereby authorize Jerry Weinberg, MD to perform the procedure listed below. The risks and benefits have been explained to me by my doctor to my satisfaction. I also understand that the doctor makes no guarantee as to the success of this procedure in delineating or diagnosing the condition that I presented with. In some cases, these procedures will need to be repeated, possibly under anesthesia on an outpatient basis.

CYSTOSCOPY is performed to survey the urethra, prostate, and/or bladder to search for the causes of urinary obstruction, incontinence, bleeding, and/or irritative urinary symptoms. This involves putting an endoscope through the urethra. The risks of the procedure include, but are not limited to, worsening of your obstruction or irritative voiding symptoms, bleeding (potentially requiring more aggressive interventional procedures), painful urination, bladder or urethral perforation, and infections (potentially requiring hospitalization).

I understand that I will be given adequate and appropriate post procedure instruction and will do my best to comply with them along with following up at the appropriate post-procedure interval. I know to call the doctor immediately for any of the side effects mentioned above, especially high fever, profuse bleeding and/or pain.

Patient Signature: ______________________________________ Date: ______________

Witness: ____ Date: ______________

Antibiotic: Given: _______________ **Ordered:** _____________________ **Date:** _____________

Nurse Signature: _______________ **Patient Signature:** ____________ **Date:** _____________

Physician Signature: ____ **Date:** _____________