

Patient's Consent to Medical Procedure

Lithotripsy ESWL

Name, surname _____

Personal code _____

I (or Patient's guardian), _____, do hereby certify by my signature that I have received the information provided by the nurse/doctor about the planned lithotripsy procedure and use of sedoanalgesia during the procedure.

I am informed that no eating or drinking is permitted for 4 hours before the procedure.

I have informed the anaesthetist about any concurrent disorders, allergic reactions (if observed before) that I have; any drugs, blood-thinning, blood-pressure and heart-rate control medications that I take; and dental prostheses (if any) and a pacemaker (if any) that I have.

I am aware that sedatives and narcotic analgesics will be used by the doctor during the procedure. This will affect the ability to work and concentrate, therefore I agree not to drive a vehicle within the next 12 hours after administration of the narcotic medications and will use a guide to assist me in getting home. I will not do anything that requires concentration and may pose a threat to my health and life or to that of other persons, and I will not use alcohol.

I am aware that in rare cases, unforeseen circumstances may occur during the procedure that may alter its course.

⚠ I am aware that urine may be red during the first day after the procedure, which is not to be regarded as a complication. In rare cases severe pain, chills, increased body temperature above 37.5C may occur during or after the procedure. In this case please consult your consultant/attending physician or call the ambulance on 113.

Patient: _____
(name, surname) (signature)

Date: _____ **Time:** _____

