Northwestern Medical Faculty Foundation, Inc.

William J. Catalona, MD

Department of Urology
675 North St. Clair Street
Suite 20-150
Chicago, Illinois 60611
Tel (312) 695-8146
Fax (312) 695-7030
www.nmff.org

Surgery Consent Form

I understand the planned operation, the removal of pelvic lymph nodes and the prostate gland.

I understand the risk of this procedure including:

1. Impotency
2. Incontinence
3. Blood Clots
4. Bleeding (requiring transfusion with its possible effects, ie; Hepatitis, AIDS, and Others)
5. Infection
6. Heart Attack
7. Intestinal Injury
8. Nerve Injury
9. Ureteral Injury
10. Others

Other alternative treatments have also been offered:

1. Radiation Therapy
2. Hormonal Therapy
3. Cryosurgery
4. Seed Implantation Therapy
5. Combined Hormonal and Radical Prostatectomy
6. Laparoscopic or Robotic Prostatectomy
7. No treatment

Signed:------------------------------------ Witness:-------------------------------
Date:------------------------------------

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If the lymph nodes come back positive on frozen section, <u>**I do not**</u> want Dr. Catalona to remove the prostate gland.

Signed:------------------------------------ Witness:-------------------------------

I want Dr. Catalona to remove the prostate gland regardless of whether the lymph nodes are involved.

Signed:------------------------------------ Witness:-------------------------------

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I wish Dr. Catalona to perform nerve-sparing surgery if feasible.

Signed:------------------------------------ Witness:-------------------------------

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I have viewed the video on Dr. Catalona's website (www.drcatalona.com) explaining the treatment options for prostate cancer.

Signed:------------------------------------

NM Northwestern Memorial Hospital

CONSENT TO OPERATING ROOM/DELIVERY ROOM PROCEDURES

1. I consent to the performance of the following procedure upon the patient named:

RADICAL RETROPUBIC PROSTATECTOMY + PLND

Name of Procedure

Common name of procedure

Additional information (optional)

I understand that a number of individual procedures may be required in order to perform the procedure named above, such as blood transfusions, medication, and other procedures. My consent to the procedure named above is also an authorization for these procedures, unless an exception is noted.

State exception, if any, or NONE

2. If any presently unknown conditions are revealed in the course of the procedures named above which call for different or further procedures, I hereby consent to and authorize the performance of such procedures as well upon the patient named above.

3. I hereby consent to receive autologous, directed, or volunteer bank blood or blood components based on my clinical condition and the potential benefits, given my individual needs. The alternative risks of receiving these components and the alternatives and risks of not receiving blood or blood components have been explained to me. The anticipated benefits may include one or more of the following: Increased oxygenation, prevention of active bleeding or stopping of abnormal bleeding, maintenance of blood pressure, improvement of blood flow, prevention of infection, and sustaining life. Possible side effects include: Fever, rash, headache. Other more serious side effects are rare and may include: Blood transfusion reactions or infections like Hepatitis or HIV/AIDS.

4. Dr. CATALONA, the attending physician(s) will perform ~~or supervise the performance of~~ TSK this procedure. I authorize the physician performing this procedure to obtain the assistance of other physicians and other professional staff to include residents, professional staff and students as he considers advisable. In addition, I authorize the physician performing this procedure or his assisting physician to administer anesthesia to the patient named above as required during the course of the procedure.*

5. Northwestern Memorial Hospital is a teaching hospital, and medical education and research is part of the Hospital's role. For the purpose of advancing medical education, I consent to observation of this procedure by qualified observers (including medical and nursing students). I also authorize the Hospital and its agents, employees and physicians to take pictures during the procedure and to publish the pictures in scientific journals and exhibit them for educational purposes, providing that the identify of the above named patient is not revealed. (If the patient's identity would be revealed by publication of the pictures or accompanying text, they will not be published unless I specifically agree to this in writing). In addition, I authorize the Hospital to retain any specimens of tissues taken from the patient's body, for research or teaching purposes.

6. A physician has explained the procedure to me and informed me of the risks involved in this procedure. I was informed of the risks involved if the above named patient did not undergo this procedure. I was also informed of possible alternative methods of treatment, and of the risks involved in these alternative methods. I have had an opportunity to discuss this procedure with a physician, and have received answers to all questions I asked.

7. The possible outcomes of this procedure have been explained to me, and I understand there is NO GUARANTEE that any particular results will be obtained.

I have read and understood all the sections of this consent form. All the blank spaces above were filled in before I signed the form. If any items were stricken from the printed form or from any handwritten items, my initials were placed next to the stricken items before I signed the form. I understand that by signing this, I am authorizing the procedure named on the first and second blank lines of the form. If I change my mind, I must notify the physician immediately.

Signature of Patient | Date & Time

USE THIS PART ONLY IF PATIENT IS INCOMPETENT. (See Patient Care Policy 5.33.)

Signature of Person Authorized to Consent for Incompetent Patient | Date & Time

Relationship to Patient

Patient did not sign this Consent because

STATEMENT OF PHYSICIAN

I certify that at the time the above consent was signed, the person who signed was capable of understanding the nature of the patient's physical condition and of the proposed treatment including blood transfusion and moderate sedation if applicable; the risks involved in the proposed treatment and in any reasonable alternatives to the proposed treatment; and the risks involved in refusal of the proposed treatment.

I certify that I explained to the person signing this consent the items described in Paragraph 5 of the Consent to Operating Room/Delivery Room Procedures, that I answered the signer's questions concerning them, and that I witnessed the signature of the patient, or other person authorized to consent for the incompetent patient named above.

Signature of Physician | Date & Time

*Note: If anesthesia is to be administered by an anesthesiologist, the patient must sign the Consent to Anesthetic Management (Form No. 411355) in addition to the Consent to Operating Room/Delivery Room Procedures.

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