INTERSTIM PROCEDURE PREP

Your physician has scheduled you for an InterStim® procedure. Please follow the instructions below.

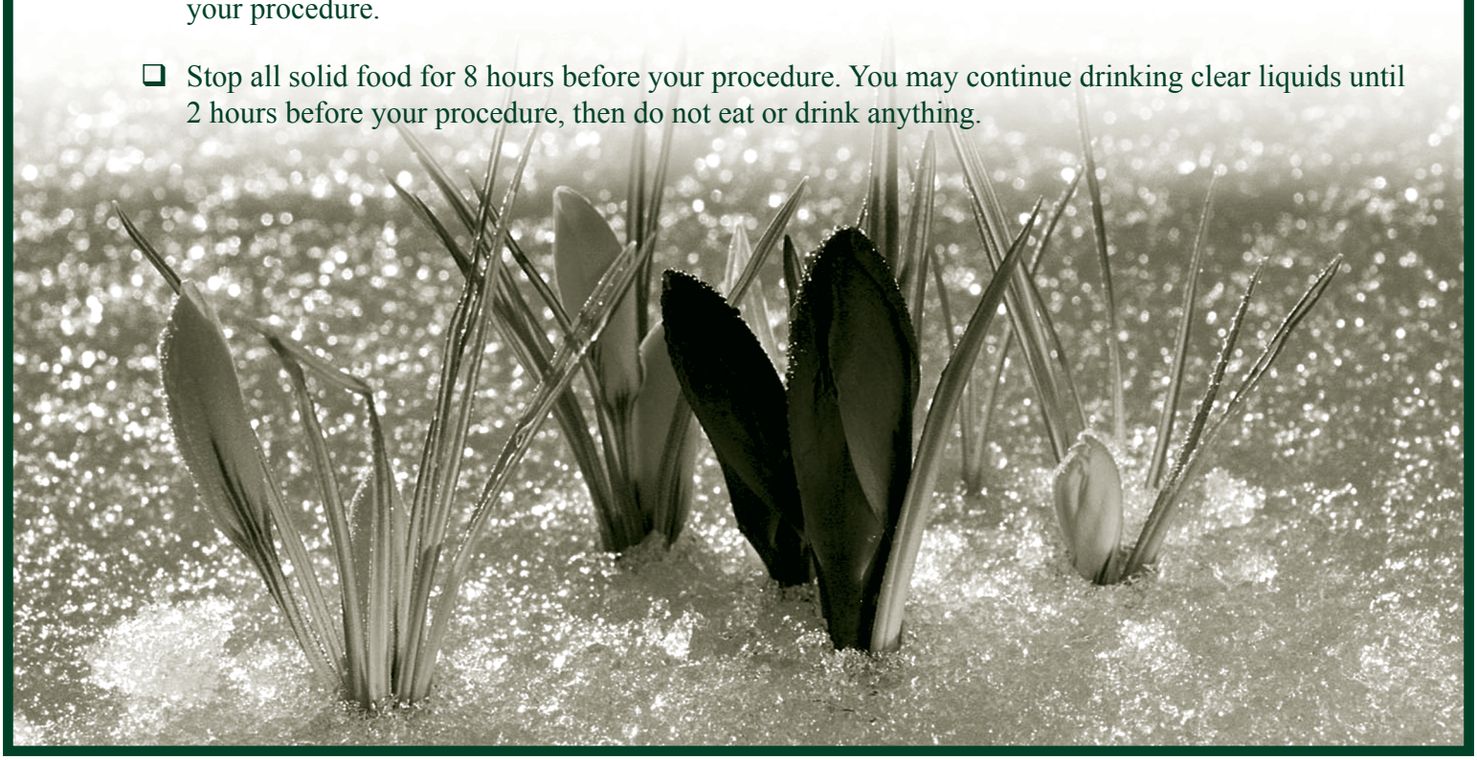
- ❑ If you need to cancel or reschedule your procedure for any reason, please call the Endoscopy Scheduler at 970-663-2159 at least 48 hours prior to your procedure.
- ❑ **Completely fill out the "TELL US ABOUT YOURSELF" and "MEDICATION FORM" in your packet. Bring the completed forms and your packet with you the day of your exam.**

General Information:

- ❑ Document your stools and incontinence episodes using the diary sheets provided (Bowel Symptom Tracker). Please provide at least 6 days of information.
- ❑ No aspirin or other blood thinning medications should be taken for seven days prior to the procedure. If you are taking blood thinners, please call Dr. North's office at 970-669-5432 if you have questions.
- ❑ Do not eat or drink anything for 2 hours before your procedure. (Take **nothing** by mouth for these 2 hours.)
- ❑ Follow the instructions given to you by Dr. North.
- ❑ Bring a photo ID and insurance card(s).
- ❑ If you do not receive sedation, you will be able to drive yourself home.

If you receive sedation:

- ❑ Make arrangements to have a responsible adult drive you home. Public transportation is not allowed unless you have an adult to accompany you. Your driver should plan to stay at the facility during your procedure.
- ❑ Stop all solid food for 8 hours before your procedure. You may continue drinking clear liquids until 2 hours before your procedure, then do not eat or drink anything.



WHAT TO EXPECT AFTER YOUR INTERSTIM PROCEDURE

Dear Patient:

Please follow these guidelines to ensure the best possible outcome after your procedure:

- ✔ Start documenting your incontinence/stooling again in the diary (Bowl Symptom Tracker), just as you did prior to the procedure. Bring this with you to the next office appointment.
- ✔ Take Tylenol for pain if needed.
- ✔ Dressings over the lead wires should not be removed.
- ✔ Do not shower or soak in a bath. Please only sponge off, or use wet wipes to clean.
- ✔ Keep the next doctor's appointment. We will remove the leads at that time.
- ✔ Limit exercise and excessive bending at the waist.

Report the following to Dr. North:

- ✔ Signs of infection: fever over 101 degrees; redness, tenderness or swelling at the site; foul smelling yellow drainage from the site (a small amount of drainage is normal).
- ✔ If you have any questions regarding these instructions, your medications, or allowed activities, please call 970-669-5432.

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INTERSTIM PROCEDURE CONSENT FORM

CONSENT FOR PROCEDURE

SKYLINE ENDOSCOPY CENTER

PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODES

Patient: _____

1. PROCEDURE AND ALTERNATIVES: I (patient or authorized representative) authorize Dr. North to perform procedure: Percutaneous Implantation of Neurostimulator Electrodes.This procedure involves putting a small needle into the sacrum in the vicinity of the nerves that control my bowel function. A thin lead will be inserted through the needle and connected to a battery operated device that will provide stimulation of the nerves.

I understand the reason for the procedure is: Testing to determine if stimulation through temporary leads will reduce or eliminate bowel symptoms / fecal incontinence.

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, allergic reactions, pain in the area of procedure, no relief of bowel symptoms / incontinence.

3. SEDATION / ANESTHESIA: This procedure will be done under local anesthesia (injection of local anesthetic / numbing medication in the area of the procedure). A small dose of IV sedation (Versed) may be administered for my additional comfort. I consent to the use of such analgesia and sedation as considered necessary by Dr. North.

4. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not relieve the condition of bowel symptoms/fecal incontinence.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THE PROCEDURE, OR THE RISKS OR CONSEQUENCES ASSOCIATED WITH IT, TALK WITH YOUR PHYSICIAN. YOU MAY WITHDRAW THE CONSENT FOR THIS PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE. DO NOT SIGN THIS CONSENT UNLESS YOU HAVE READ AND UNDERSTAND THIS FORM.

_____ _____

Patient / Authorized Representative **Date and Time**

_____

Relationship of Authorized Representative

PHYSICIAN DECLARATION: I have discussed the procedure, risks, complications, consequences, and alternatives with the patient or patient's representative, and to the best of my knowledge, the patient or patient's representative understands this information and consents to the proposed procedure.

_____

Physician's Signature

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