# 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**

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**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.

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**Physician's Signature**