CENTER FOR UROLOGY
ABRAHAM L. WOODS, M.D.
106 BOSSTON AVENUE SUITE 103
ALTAMONTE SPRINGS FLORIDA 32701
PH: (407) 830-4777 FAX: (407) 830-4762

CYSTOSCOPY CONSENT FORM

Dr. Abraham L. Woods lll has discussed with me the nature and purpose of a cystoscopy with possible urethral dilation. He has also advised me of possible risks of this procedure and desired objectives.

I hereby authorize Dr. Abraham L. Woods lll, and/or such assistants as he may select to perform said Cystoscopy/Dilation.

Patient Name (Please Print): ____________________

Patient's Signature: ____________________

Date: ____________

Witness Name (Please Print): ____________________

Witness Signature: ____________________

Please circle answers:

Taken Antibiotics?	**Yes**	**No**
Taken Any Aspirin or Aspirin Products?	**Yes**	**No**
Taken Any Blood Thinners?	**Yes**	**No**

Center for Urology and Wellness

CYSTOSCOPY REPORT MALE

DATE__________________PATIENT NAME: ____

DIAGNOSIS: ______________________________

OPERATION: [ ] CYSTOSCOPY [ ] CYSTO AND CAL/DIL
[ ] CYSTO AND INSTILL [ ] CYSTO AND BLADDER WASHING

SURGEON: ABRAHAM WOODS, M.D.
ANESTHESIA: [ ] 2% XYLOCAINE JELLY [ ] OTHER ______________________________

Right

Left

RESIDUAL: ________ ccs

U/A:

URETHRA:

RECTAL

PROSTATE:

BLADDER:

U.O.s

TRABEC none + ++ +++ ++++

FINDINGS OF NOTE: ____

____

COMPLICATIONS: : [ ] NONE ____

MEDICATIONS POST CYSTO: [ ] NONE [ ] FLOXIN [ ] CIPRO [ ] LEVAQUIN [ ] OTHER ________

SIGNATURE ____________________________