Dr. Herman C. Kwan Inc., Urologic Surgery
Dr. H. Kwan, BSc, MD, FRCSC
#300 - 2099 - 152 Street, Surrey, B.C. V4A 4N7 Tel: (604)536-1801, fax: (604) 536-1860

Dr: _____
Re: _____
PHN: _____DOB: _____

Please send all pertinent Urologic investigations - Urine tests, Ultrasounds, CT scans, PSA's for male patients and previous Urologic consultations.

Patient will be seen at Peach Arch Hospital for a Cystoscopy/consult.

Please have patient fill out all forms and bring to the appointment.

Your appointment date and time is:

DATE: _____
TIME: _____ ARRIVE: _____

Please remember:
1) Phone Dr Kwan's office as soon as possible to confirm your appointment
2) Bring your Care Card/Proper ID
3) If you need reading glasses, please bring them with you.
4) Bring a list of all of your medications, allergies, previous surgeries and medical conditions
5) Bring a translator if required
6) PLEASE NOTIFY PATIENT THERE WILL BE A $100 NO SHOW FEE

Flexible Video Cystoscopy Dr. Herman Kwan

Appointment Date and Time: _____

Where do I check in? Go to the Admitting Desk on the main floor at Peace Arch Hospital to register. Please arrive 30 minutes prior to the procedure. From there, you will be directed to the Surgical Daycare Department. There may be a delay. Bring some reading material.

Where is this performed? At the Surgical Daycare Department (sometimes referred to as SOP for Surgical Outpatient Department) at Peace Arch Hospital.

What is flexible video Cystoscopy? A flexible video cystoscopy it's a brief inspection of the urethra and the bladder with a small flexible catheter containing a tiny video camera. You will be able to see the image on the screen. Special lubricant containing local anesthetic is used to minimize discomfort. The entire procedure takes 3 to 5 minutes. As this is a diagnostic visit, there will be no time to discuss in detail your results and treatment plan, so please make a follow-up office appointment.

What preparation is required? There is no special preparation. You may drive yourself to and from the hospital. Please empty your bladder a few minutes before the procedure. For women, having your menstrual period will not interfere with the procedure.

What can I expect afterwards? Resume your normal diet and activities. Drink plenty of fluids for a day are two. Occasionally mild discomfort is felt upon emptying the bladder afterwards. Very infrequently a small amount of blood can be seen. This should clear in 1 to 2 days.

When should I seek medical attention? Please note that the following events occur infrequently (less than 1% of the time). Please contact your Urologist's office during business hours or proceed to the Peace Arch Emergency after hours if any of the following occur:

- Bleeding or burning does not resolve in a day or two.
- Increasing size or number of blood clots after the procedure.
- Fever (temperature above 38C or 100.4 F)
- Sudden chills or shaking.
- Cloudy or foul smelling urine.
- Voiding often, unable to void or unable to empty your bladder when you void.

BASIC INFORMATION

Name _____ Height _____ Weight _____ Gender _____

MALE PATIENTS:		**FEMALE PATIENTS:**	
Family history of prostate cancer?		Previous gynaecologic surgery?	
Have you had a Vasectomy?		Number of pregnancies:	
Have you had a previous PSA test?		# of Vaginal deliveries:	
		# of C-section deliveries:	
DO YOU HAVE:		Comments	
Diabetes			
Hypertension (High Blood Pressure)			
Previous Heart Attack			
Previous Stroke			
Liver / Stomach / Bowel Disease			
Bleeding / Clotting Disorder			
Sleep Apnea			
Artificial heart valve?			
Are you on blood thinners?		If yes, please name?	
Please list ALL previous surgeries:		Please list ALL current medications:	

Allergies _____

Have you ever smoked? If yes, for how many years? _____ # of cigarettes /day _____

Alcohol consumption: # of drinks in a typical week? _____

Occupation _____

URINARY SYMPTOMS

1. On a typical night, how many times do you need to get up to urinate? _____
2. When you get the urge to urinate, can you hold it or do you have to go right away?

   _____
3. On a typical day, how often do you empty your bladder? _____
4. What is your urinary flow like? Weak? _____ Strong? _____ Dribbling? _____
5. Do you ever leak urine?
6. Fluid Consumption: Caffeinated beverages per day: ___ Non-caffeinated beverages per day: _____

fraserhealth

Regional
CONSENT FOR HEALTH CARE

CWXX104852A Rev.: June 2011

PATIENT SURNAME	FIRST NAME	OTHER NAMES	DOB (d/m/yyyy)	CARE CARD #

Section 1: Provider*Statement

Details of proposed health care treatment, procedure or treatment plan (print legibly and in full without abbreviations)

flex cystoscopy

I have discussed the proposed health care and related risks with the patient or substitute decision-maker who, in my opinion, understood the information provided.

Provider Name (print) Dr. H. KWAN Signature _____ Date (d/m/yyyy) _____

*Note: Provider refers to the most responsible health care provider proposing and/or performing the health care.

Section 2: Patient or Substitute Maker Consent

Please note: You have the right to ask questions and receive answers about your health care.

I, X _____ consent to the health care described above. The nature and anticipated effect of the proposed case, including the
(Print Name)

significant risks and available alternatives have been explained to me. I am satisfied with and understand the explanations. I also understand that:

a) My provider may make use of other health care providers (including trainees) who may attend and/or assist in my care under the direction of my provider
b) If tissues, body fluids or implants are removed during my care, they may be used for diagnostic examination, education or quality improvement purposes.
c) If a health care worker is exposed to my blood or body fluids during my care, my blood will be tested for risk assessment purposes for Hepatitis B, Hepatitis C, HIV. The test results will be confidential and will and will only be used to treat the health care worker. If positive, the test results will be reported to public health authorities as required by law (Provincial Health Act) and I will be offered treatment
d) If my care includes inserting a medical device, my personal information will be shared with the supplier of the device for my safety, and will come under the privacy laws of the country where the supplier is located

Signature X _____ Date (d/m/yyyy) _____

☑ Patient ☐ Parent/Legal Guardian ☐ Substitute Decision Maker *

*Note: If signed by a Substitute Decision Maker, complete the Confirmation of Substitute Decision Maker form.

Section 3: Administration of Blood Components/Products (if applicable) ☐ **Not Applicable**

My provider told me it may be necessary for me to receive blood components or blood products during my treatment.

☐ Yes, I consent to receive blood components/products ☐ No, I refuse blood components/products*

Signature X _____ Date (d/m/yyy) _____

☐ Patient ☐ Parent/Legal Guardian ☐ Substitute Decision Maker *

***Note: If consent is refused, the Refusal of Blood Components/Products Administration form must be completed.**