

**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 III 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 III, 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:**

<b>Taken Antibiotics?</b>	<b>Yes</b>	<b>No</b>
<b>Taken Any Aspirin or Aspirin Products?</b>	<b>Yes</b>	<b>No</b>
<b>Taken Any Blood Thinners?</b>	<b>Yes</b>	<b>No</b>

**Center for Urology and Wellness**

**CYSTOSCOPY REPORT FEMALE**

DATE \_\_\_\_\_

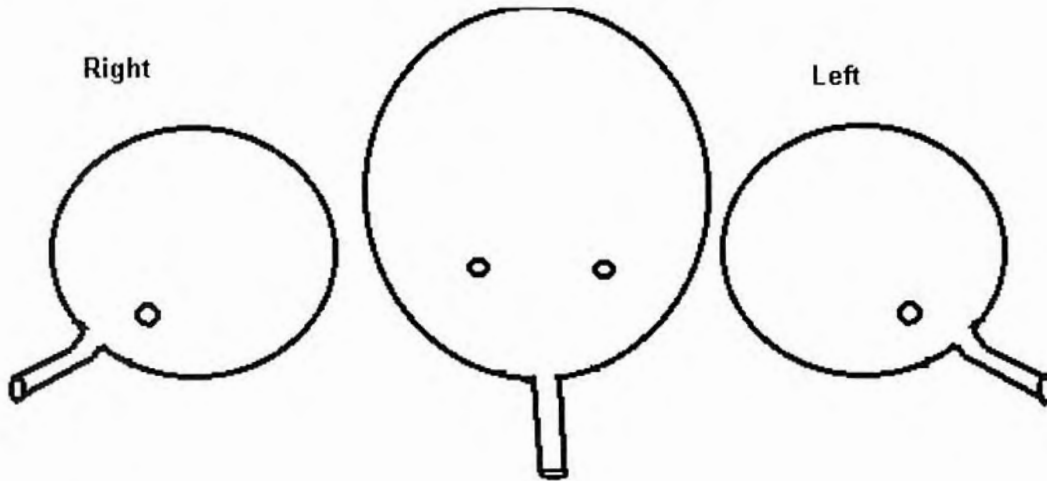
PATIENT NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

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

SURGEON: Abraham Woods MD

ANESTHESIA:  2% XYLOCAINE JELLY  OTHER \_\_\_\_\_



RESIDUAL:

U/A:

PELVIC:

RECTAL:

URETHRA:

BLADDER:

U.O.s

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

FINDINGS OF NOTE: \_\_\_\_\_

COMPLICATIONS: :  NONE \_\_\_\_\_

MEDICATIONS POST CYSTO:  NONE     FLOXIN     CIPRO     LEVAQUIN    OTHER  
 \_\_\_\_\_

SIGNATURE \_\_\_\_\_