INFORMED CONSENT FORM FOR TREATMENT USING LOW INTENSITY LINEAR SHOCKWAVE TREATMENT (LI-LSWT) FOR ERECTILE DYSFUNCTION

LI-LSWT treatment is a novel and pain free outpatient treatment designed to improve the blood supply to the penis. These low intensity shock waves stimulate growth of new blood vessels thereby improving the blood flow to the penis during sexual arousal.

This type of energy has already been widely used to treat stones in the kidney and ureter for many years and has proven to be safe for use in human beings.

Results are expected to match with that of other centres but no guarantee of effectiveness of therapy can be offered.

There are no known side effects of the treatment.

I _____

hereby authorise Dr/Mr _____

to perform the procedure of LI-LSWT for the treatment of erectile dysfunction.

I am aware that the actual treatment may be carried out by any suitably trained personnel, under his/her supervision.

I am aware that various alternatives are currently available for treatment of erectile dysfunction including medicines, injections, vacuum therapy, surgical implants etc. and have carefully considered my options and have agreed to undergo LI-LSWT treatment without any reservations.

I have carefully considered the pros and cons of each form of treatment and wish to participate in the LI-LSWT treatment. I understand that my participation for LI-LSWT treatment is entirely voluntary.

I fully understand the risks and benefits of the procedure listed above. I am aware that there are no currently reported side effects apart from mild altered sensation at the site of probe application.

I know that the results cannot be guaranteed and the treatment may or may not improve my condition.

The machine used for the procedure is CE marked and covered by manufacturers liability by Howden, Israel, Policy number

I am happy for my treatment related data to be collected in an anonymised non identifiable way for research purposes and future clinical and commercial use.

By signing below, I state that I am 18 years or older or otherwise authorised to consent. I have read or have had explained to me the contents of this form and I agree to receive the treatment listed on this consent. I have had a chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Signature: _____ Doctor Signature: _____

Date: _____ Doctor Name: _____