

Patient Consent Form

**THERMATRX'S MICROWAVE THERMOTHERAPY TREATMENT
FOR THE TREATMENT OF BENIGN PROSTATIC HYPERPLASIA**

I, _____, hereby authorize Dr. _____ to perform the **TherMatrix Microwave Thermotherapy** for the treatment of **Benign Prostatic Hyperplasia**. This treatment will be performed on _____. I understand that during the treatment a catheter-like tube will be inserted into my urethra using anesthetic jelly. There will also be a small probe inserted into my rectum. These probes will be connected to the microwave generator. This treatment has been used investigationally since 1988 and received FDA approved in 2001.

The benefit of this treatment is relief of my bladder outflow obstruction. I understand the possibility of risks associated with transurethral microwave thermotherapy. Some of the risks include blood in my urine, small amounts of blood in the sperm, temporary inability to urinate, frequent urination, urgency, discomfort in the bladder or rectum, and a burning sensation during urination. I understand these will be short-term side effects and should subside in a few days. Additional possible side effects that were not noticed in the clinical study included loss of sexual functioning, sterility, exposure to excessive microwave energy, and heat damage to tissue.

My physician has explained alternative methods for the treatment of benign prostatic hyperplasia. Alternatives include watchful waiting, drug therapy, surgical procedures such as transurethral resection of the prostate, open prostatectomy, and other heat therapies. My physician has discussed these alternatives with me and feels that microwave thermotherapy is the best treatment for my particular condition. The doctor has answered all my questions regarding this treatment and I agree to proceed with the TherMatrix Microwave Thermotherapy treatment.

My signature below indicates that I have read and understood this consent form.

Signed _____

Witness _____

Date _____

Time _____