



**INFORMED CONSENT TO
COLPORRHAPHY (ANTERIOR AND/OR POSTERIOR)
WITH VESICO URETHRAL ANGLE SUSPENSION AND CYSTOSCOPY
WITH SUPRAPUBIC CATHETER AND REPAIR OF RECTOCELE**

It is very important to Women's Health Center of Lebanon that you understand and consent to the treatment your doctor is rendering and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

Patient's Initials or Authorized Representative

Date

I, _____, hereby authorize Dr. _____ and any associates or assistants the doctor deems appropriate, to perform an anterior and/or posterior colporrhaphy.

The doctor has explained the benefits of the procedure(s) to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

Proposed Procedure: Colporrhaphy is the surgical repair of a defect in the vaginal wall, including a cystocele (when the bladder protrudes into the vagina) and a rectocele (when the rectum protrudes into the vagina).

Colporrhaphy may be performed on the anterior (front) and/or posterior (back) walls of the vagina. Surgery is generally not performed unless the symptoms of the prolapse have begun to interfere with daily life.

_____ **Anterior Colporrhaphy.** An anterior colporrhaphy treats a cystocele (protrusion or prolapse of the bladder into the vagina) or urethrocele (prolapse of the urethra into the vagina).

_____ **Posterior Colporrhaphy.** A posterior colporrhaphy treats a rectocele (rectum prolapses into the vagina).

The patient is first given general, regional, or local anesthesia. A speculum is inserted into the vagina to hold it open during the procedure. An incision is made into the vaginal skin and the defect in the underlying fascia is identified. The vaginal skin is separated from the fascia and the defect is folded over and sutured (stitched). Any excess vaginal skin is removed and the incision is closed with stitches.

Risks/Possible Complications: The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood clots, infection, blood loss, transfusion, adverse reaction to anesthesia, injury to other pelvic structures, possible delayed or prolonged healing of the skin, painful intercourse, recurrent prolapse (repeated falling or slipping out of place of the rectum into the vagina), urinary leakage, fistula (abnormal connection between organs), and/or failure to correct the defect. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases.

Post-Procedure Requirements: You may be required to follow a liquid diet until normal bowel function returns. You should avoid activities for several weeks that will cause strain on the surgical site, including lifting, coughing, long periods of standing, sneezing, straining with bowel movements and sexual intercourse.

In permitting my doctor to perform the procedure(s), I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician(s) will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

Alternative Procedures: The reasonable alternative(s) to the procedure(s) have been explained to me. These alternatives include, but are not limited to: _____

The risks of the alternatives include, but are not limited to: _____

I hereby authorize the doctor to utilize or dispose of removed tissues, parts or organs resulting from the procedure(s) authorized above.

I consent to any photographing or videotaping of the procedure(s) that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them, so that my physician may follow my therapy progression. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

_____/_____/_____
Date Time Signature of Patient or Authorized Rep. Relationship of Authorized Rep.

