



INFORMED CONSENT FOR COLPOSCOPY WITH BIOPSIES

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 a colposcopy (examination of the vagina, vulva and cervix) with biopsies.

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: A colposcopy is a way the doctor can examine your vagina, vulva (vaginal opening) and cervix closely. A colposcope is an instrument that shines a light on the cervix and magnifies the view for the doctor. At the beginning of the exam, you lie back and place your feet in the stirrups as you would for a Pap smear. The doctor inserts a speculum into your vagina and opens it slightly so he/she can see your cervix. Then the doctor applies a vinegar solution to the cervix and vagina with a cotton ball or swab. The vinegar makes abnormal tissue turn white so the doctor can identify areas that may need further evaluation. If the doctor sees areas of abnormal tissue during the colposcopy, he or she may perform a biopsy. This involves removing small samples of tissue from any abnormal areas in or around the cervix.

Risks/Possible Complications: The doctor has explained to me that there are risks and possible undesirable consequences associated with this procedure including, but not limited to, cramping, infection, bleeding, possible delayed and prolonged healing of the skin, and possible insufficient tissue for pathologic analysis. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases.

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/her assistants, or his/her 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), as well as the risks to the alternatives, have been explained to me. The alternatives include, but are not limited to, continued observation (risking a possible undiagnosed condition or malignancy and future risk of malignancy).

I hereby authorize the doctor to dispose of any removed tissue resulting from the procedure(s) authorized above.

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.

- The Patient/Authorized Representative has read this form or had it read to him/her
- The Patient/Authorized Representative states that he/she understands this information
- The Patient/Authorized Representative has no further questions
- The Patient/Authorized Representative has read the form in Spanish.

I certify that I have asked the patient/authorized representative the above questions and her responses were noted above.

Date Time Signature of Witness

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Date Time Signature of Physician

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual Providing Assistance)

Date

Time