



**INFORMED CONSENT TO
DIAGNOSTIC/OPERATIVE LAPAROSCOPY**

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 diagnostic laparoscopy.

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: Diagnostic/operative laparoscopy is a procedure that allows the doctor to look directly at the contents of your pelvis, including the fallopian tubes, ovaries, and uterus, to determine the presence or absence of certain gynecological diseases. It is performed by making a roughly half-inch incision through the belly button and passing a telescope-type device through the incision into the abdomen. Gas (CO2) is infused to create a space inside the abdomen for viewing and operating (if that is appropriate and necessary). For operating or manipulation of tissues, it is necessary to place one or more smaller ports for the passage of instruments at other varied positions on the abdomen.

Laparoscopy can be performed simply for inspection purposes with the intent of arriving at a diagnosis, or it can be performed with the intent of operating. Operative laparoscopy includes such procedures as cautery (destroying of tissue) or excision (removal) of lesions, biopsy of organs, lysis (division/separation) of adhesions (scar tissue which causes abnormal adherence and fixation of organs) or removal of organs, tubes, ovaries, or the uterus.

Risks/Possible Complications: The doctor has explained to me that there are risks and possible unintended consequences associated with this procedure *including, but not limited to*, adverse reactions to anesthesia (which will be explained to me by the anesthesiologist); bleeding with subsequent need for transfusion; infection of the wound, lungs (pneumonia), abdominal lining (peritonitis), blood (sepsis), or urine; adhesion formation (scar tissue); possible delayed or

prolonged healing of the skin; hernia formation at the operative site; injury to the bowel, bladder, ureters, blood vessels or other intraabdominal organs that may result in leakage, obstruction, bleeding, or fistula formation (a passage or hole that forms between two organs in the body) and may require subsequent surgery for treatment; chemical or thermal burns or injury; blood clot formation within the vascular system (DVT); pulmonary emboli (blood clots which travel to the lungs); death; loss of fertility; depression; loss of sexual pleasure; and/or allergic reactions to medications. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other viral diseases.

Whenever diagnostic/operative laparoscopy is undertaken, it is possible the operation may have to be converted to an open abdominal procedure in order to overcome difficulties such as bleeding, adhesions, or other pathologic conditions or for safety concerns. A transverse or vertical midline incision is made to complete the operation.

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.

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, the facts, 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