



## INFORMED CONSENT FOR ENDOMETRIAL ABLATION

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 endometrial ablation (destroy the uterine lining to control bleeding).

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:** Endometrial ablation is a procedure that uses a lighted viewing instrument (hysteroscope) and other instruments to destroy (ablate) the uterine lining or endometrium. Endometrial ablation is used to control heavy, prolonged vaginal bleeding when: bleeding has not responded to other treatments, childbearing is completed, you prefer not to have a hysterectomy to control bleeding, and/or other medical problems prevent a hysterectomy.

**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**, development of anesthetic problems, bleeding, infection, and unintended surgical trauma, including but not limited to uterine perforation (puncture or hole), perforation of bowel or bladder, possible delayed or prolonged healing of the skin, thermal injury to bowel or bladder or delayed detection of endometrial cancer. Painful periods (dysmenorrhea) that present prior to the procedure may persist despite successful endometrial ablation and may warrant subsequent hysterectomy.

Additional risks include adhesions (scar tissue) which may develop inside the uterine cavity and result in narrowing or blockage of the outflow tract trapping whatever residual menstrual buildup may occur in subsequent cycles following the procedure. This could lead to dysmenorrhea (painful periods), which could warrant subsequent hysterectomy and possible delay of the detection of uterine cancer in the future.

You should not attempt to get pregnant after an endometrial ablation. It is not considered safe. In fact, you or your partner should already have a sterilization procedure in effect or have one planned to be carried out at the time of your endometrial ablation. Significant complications could arise if pregnancy occurs after an endometrial ablation.

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, hormonal therapy, progesterone impregnated IUD or hysterectomy. I understand the risks associated with the alternatives include, *but are not limited to*, heavy or prolonged bleeding during menstrual cycle,

I hereby authorize the doctor to dispose of any removed tissue 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

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**CERTIFICATION OF PHYSICIAN:**

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of Physician

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**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