INFORMED CONSENT FOR ENDOMETRIAL BIOPSY

It is very important to Women's Health Care 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 endometrial biopsy (taking a small sample from the lining of the uterus).

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: An endometrial biopsy is a way for the doctor to take a small sample of the lining of the uterus. An endometrial biopsy helps the doctor find any problems in the endometrium (uterine lining). It may also be used to see if the body hormone levels that affect the endometrium are in balance.

A pelvic exam is performed to determine the size and position of the uterus. The cervix is exposed with a speculum and cleansed with an antiseptic solution. Sometimes it is necessary to grasp the cervix with an instrument to provide traction on the cervix and uterus; other times the procedure can be performed without this. A narrow-diameter catheter of semi-rigid soft plastic with a blunt-rounded tip and an opening near its end is passed through the cervical canal into the uterine cavity. Sometimes it is necessary to dilate (widen) the cervical canal in order to insert this catheter. Once inside, a small amount of vacuum is created by withdrawing a central plunger inside the catheter. A tissue specimen is obtained as the vacuum draws endometrial tissue into the catheter while it is moved about the uterine cavity.

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, perforation of the uterus, 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 (with or without hormonal manipulation risking a possible undiagnosed condition or malignancy), or a dilation and curettage (enlarging and scraping of the uterus). The risks of the alternatives include, but are not limited to: bleeding, infection, and/or injury to the cervix or uterus.

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

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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