

INFORMED CONSENT FOR OBSTETRICAL PROCEDURES

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

Vaginal Delivery

Vaginal delivery is a natural process. However, at times we need to help the delivery of the baby with what is referred to as an Episiotomy.

Episiotomy

An episiotomy may be necessary to enlarge the vaginal opening by performing a surgical incision. Risks inherent with the procedure include, **but are not limited to**, pain, discomfort with intercourse, infection, excessive bleeding, hematoma, tearing or damaged to the pelvic floor formation of a fistula (abnormal connection between the vagina and rectum), and possible delayed or prolonged healing of the skin. The alternative would be to allow a tear to occur or not doing an episiotomy which could possibly jeopardize the health of your baby. I understand that my physician will use his/her professional judgment at the time of delivery as to whether an episiotomy is indicated for my well being and/or the well being of my baby.

Operative Delivery

At times during a vaginal delivery, due to fetal distress, ineffective uterine contractions, inability to push, your doctor may suggest utilizing forceps or a vacuum device to assist you. The doctor recommends this because he/she can possibly prevent you from going to the operating room for a cesarean section or feels that under the circumstances it is the quickest and safest way to deliver your baby. However, it is important for you to understand that there are some maternal and fetal risks involved. The risks of an assisted delivery include, **but are not limited to**, fetal scalp trauma, including hematoma (collection of blood) as well as possible skull fracture. More serious injuries related to the use of either forceps or a vacuum delivery could include neurologic injury to the baby. It is also possible that your doctor may decide in his/her judgment to abandon the use of these instruments and proceed with a cesarean section.

Cesarean Section

A Cesarean section is an incision through the abdominal and uterine walls to deliver the baby. The risks of a Cesarean section have been explained to me. They include, **but are not limited to**, blood loss, transfusion reactions, infection, heart complications, blood clots, possible delayed or

prolonged healing of the skin, neurological injury or death. I understand that if I need blood or blood products there is a risk of contracting HIV/AIDS, hepatitis, or other diseases.

I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

I understand that there is no guarantee regarding the outcome of the procedure(s).

Induction of Labor

I understand that my doctor may need to induce labor with oxytocin (a hormone used to begin labor), use cervical ripening agents (synthetic dilators to begin labor) or start oxytocin to begin labor. The risks of inducing labor have been explained to me, including but not limited to, uterine rupture, fetal distress, emergency delivery by Cesarean section.

I also understand that unforeseen conditions may arise or be revealed during the procedure that may necessitate change or extension of the procedure that was explained to me. I therefore authorize and request that my physician, his/her assistants and/or appropriate designees perform such procedure as may be necessary or desirable in his/her professional judgment, for my safety and the safety of my baby.

I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being and safety.

I understand that there is no guarantee regarding the outcome of the procedure(s).

Other risks include obstetrical hemorrhage. At the time of delivery, after your baby has been born by vaginal birth or cesarean section, it is possible to develop severe bleeding, known as obstetrical hemorrhage. This may not, and often is not, able to be predicted before it occurs. This may occur because of placental abruption (premature separation of the placenta), uterine atony (“floppy” uterus), infection, retained pregnancy tissue, uterine rupture, or unknown causes. This emergency may require medications and massage of the uterus or may require emergency surgery which could include a hysterectomy (removal of the uterus) in order to control bleeding. Your doctor will use his or her clinical judgment in order to safeguard your health and will be available to you and your family to address concerns and questions.

I understand that emergencies or unforeseen medical conditions may arise at the time of my labor or delivery that may necessitate the performance of this procedure, or a change or extension of the procedure(s) explained to me. I, therefore, authorize and request that my physician, his/her assistants and/or appropriate designees perform such procedures as may be necessary in his/her professional judgment for my safety and the safety of my baby. I also understand that unforeseen conditions may arise or be revealed during the procedure that may necessitate change or extension of the procedure that was explained to me. I therefore authorize and request that my physician, his/her assistants and/or appropriate designees perform such procedure as may be necessary or desirable in his/her professional judgment, for my safety and the safety of my baby.

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.

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.

_____/_____/_____
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 PROVIDER:

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 Provider

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