



**INFORMED CONSENT TO
TRANSVAGINAL TAPE**

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 transvaginal tape procedure.

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: Transvaginal tape procedure is a minimally invasive procedure for women who suffer from stress urinary incontinence (involuntary leakage of urine when coughing, sneezing, laughing, jumping, walking, sitting or standing). During the procedure, the urinary bladder and urethra are repaired, strengthened and returned to the original position in the pelvis.

Risks/Possible Complications: The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood clots, infection, blood loss, transfusion, adverse reaction to anesthesia, injury to blood vessels of the pelvic sidewall and abdominal wall, possible delayed or prolonged healing of the skin, hematoma (collection of blood), urinary retention, bladder injury, and/or bowel injury, and fistula formation (a passage or hole that forms between two organs in the body). 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 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