INFORMED CONSENT FOR
STERILIZATION BY TUBAL LIGATION
(Laparoscopic Method)

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 laparoscopic tubal ligation.

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: Tubal ligation is surgery to block a woman's fallopian tubes, the tubes that connect the ovaries to the uterus. The procedure is commonly known as "tying the tubes." Normally, a woman's fallopian tubes moves eggs from the ovary to the uterus about once a month. If a man's sperm meets with an egg, pregnancy can result. If the tubes are closed, or "tied," sperm cannot fertilize an egg, and pregnancy will not occur. Tubal ligation makes a woman permanently sterile (unable to get pregnant).

Risks/Possible Complications: The doctor has explained to me that there are possible risks or possible undesirable consequences associated with this procedure which include, but are not limited to, damage to any organ or structure in the abdomen or pelvis (which might need a larger incision in the abdomen to repair), possibility of hernia at the incision site, possible delayed or prolonged healing of the skin, the risks of anesthesia (which will be explained to me by the anesthesiologist), bleeding, burn injury to nearby organs, or infection. I understand that if I need blood or blood products, these carry a risk of contracting HIV/AIDS, hepatitis or other diseases.

The risk of failure of tubal litigation can occur and pregnancy may occur – pregnancy can include the risk of ectopic pregnancy, which, if left untreated, could result in a life-threatening condition needing treatment with medicine or surgery.

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 alternatives to this procedure have been explained to me, along with the risks of those alternatives. Alternatives include, but are not limited to, male sterilization (vasectomy), IUD, Depo-Provera, oral contraceptives and local measures such as foam, condoms and diaphragms.

I hereby authorize, 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, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

_______________ _______________ _____________________________________

Date Time Signature of Physician

Revised 12/7/09

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

Revised 12/7/09