



## INFORMED CONSENT TO VAGINAL HYSTERECTOMY

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 vaginal hysterectomy.

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:** A vaginal hysterectomy is the surgical removal of the uterus through an incision at the vaginal cuff (top of the vagina). Through this incision, the doctor can cut and tie off ligaments, blood vessels, and other tissues which hold the uterus in place. The uterus can then be cut free and removed through this incision. No abdominal incision is made unless difficulty is encountered with the surgery.

The ovaries (glands on both sides of the uterus which release eggs and secrete hormones into your blood stream) and the fallopian tubes may also be removed. Whether or not your ovaries are removed will depend on your age, risk for developing ovarian cancer and/or the presence of disease which may involve the ovaries at the time of the surgery. The decision of whether or not to remove your ovaries will be made by you and your physician together. The ovaries cannot always be removed safely vaginally, in which case the ovaries may need to be removed by the aid of laparoscopic surgery.

**Risks/Possible Complications:** The doctor has explained to me that there are risks and possible unintended consequences associated with any procedure *including, but not limited to*, adverse reactions to anesthesia (which will be explained to me by the anesthesiologist); bleeding with subsequent need for transfusion; infection of the wound, lungs (pneumonia), abdominal lining (peritonitis), blood (sepsis), or urine; adhesion formation (scar tissue); possible delayed or

prolonged healing of the skin; hernia formation at the operative site; injury to the bowel, bladder, ureters or other intraabdominal organs that may result in leakage, obstruction, or fistula formation (a passage or hole that forms between two organs in the body) and may require subsequent surgery for treatment; chemical or thermal burns or injury; blood clot formation within the vascular system (DVT); pulmonary emboli (blood clots which travel to the lungs); death; loss of fertility; depression; loss of sexual pleasure; and/or allergic reactions to medications. I understand that whenever the ovaries are left in place after hysterectomy, there is a rare risk of an ectopic pregnancy (embryo implants somewhere other than the uterus). I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other viral diseases. After a hysterectomy, I understand that I will no longer be able to bear children and will no longer have menstrual periods. However, with supracervical hysterectomy, there is the slight chance that some cyclic bleeding may continue after hysterectomy.

If the ovaries are to be removed, this will result in surgically induced menopause, which could result in a variety of symptoms, including, but not limited to, hot flashes, night sweats, mood disturbances, sleep disorders, vaginal dryness that could cause pain with intercourse, decreased sexual libido, and/or osteoporosis. Although the intent is to completely remove the ovaries, it is possible a small remnant of ovarian tissue could be left behind resulting in ovarian remnant syndrome – a situation where a cyst develops from the remnant, possibly causing pelvic pain.

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