

SURGICAL INFORMED CONSENT – Please Complete If You Pursue Surgery

Patient Name: _____

You have been given a copy of the notes that discuss your surgery. The notes may also provide a list of the risks and hazards related to the performance of surgical and/or diagnostic procedures.

Please refer to your Consultation notes for a list of the recommended surgical procedures that have been scheduled.

DISCLOSURE: My doctor has given me full disclosure regarding my surgery. I have had a chance to read any handouts that may have been provided to me. I understand what I am having done and the extent of surgery provided.

QUESTIONS: I have had a chance to ask all the questions I have requested and have been satisfied with the answers given. I am free to ask questions at any time. I have no further questions at this time.

BENEFITS: Surgery attempts to improve conditions that can be treated with an operation. Surgery cannot provide patients a guarantee of either a short-term or permanent cure. You should realize that you may have other conditions that cannot be treated with surgery and, in some cases, may risk worsening following surgery.

RISKS: There are risks and hazards related to the performance of surgical, medical, and/or diagnostic procedures. These risks include, but are not limited to:

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|---|---|
| <input type="checkbox"/> Bleeding, infection (general, bladder) | <input type="checkbox"/> Granulation tissue (failure of vaginal incision to heal) |
| <input type="checkbox"/> Pain (general pain or pain with sex; brief or chronic/ lifetime) | <input type="checkbox"/> Implant problems (pain, erosion, infection, need to remove) |
| <input type="checkbox"/> Injury to urinary tract (bladder, urethra, ureters) | <input type="checkbox"/> Persistence / recurrence of any or all conditions (as before surgery requiring additional surgical/non-surgical procedures and expenses) |
| <input type="checkbox"/> Injury to gastrointestinal tract (rectum, bowel) | <input type="checkbox"/> Requirement for additional surgery to correct any post-operative complications |
| <input type="checkbox"/> Injury to nerves (loss of sensation, hypersensitivity and irritation, pain, loss of muscle control) | <input type="checkbox"/> Anesthesia-related complications (complete discussion deferred to attending anesthesiologist) |
| <input type="checkbox"/> Overactive bladder /urgency (<u>NOT</u> corrected by surgery and may persist or worsen) | <input type="checkbox"/> Blood clot (including veins, lungs) / death |
| <input type="checkbox"/> Urethral outflow obstruction (may require short- or long-term self-catheterization to empty bladder) | |
| <input type="checkbox"/> Fistula (hole in vagina from which stool or urine passes) | |

Please initial /date: _____

Laparoscopy (diagnostic / operative)

- | | |
|---|---|
| <input type="checkbox"/> Inability to complete procedure via laparoscopy requiring abdominal incision | <input type="checkbox"/> Embolization of carbon dioxide gas to heart or lungs causing shock |
|---|---|

If you are having laparoscopy, please initial /date: _____

Hysterectomy (uterus removed with/without cervix)

- Inability of future childbearing / inability to become pregnant
- Injury to fallopian tubes or ovaries with possible removal of one or both ovaries
- If cervix not removed, possible requirement of medical treatment or surgical removal in future
- If cervix not removed, possible vaginal bleeding due to retained endometrial glands (approx. 2-5%)

Oophorectomy (removal of one or both ovaries)

- Inability of future childbearing / inability to become pregnant
- Absence of estrogen (hot flashes, osteoporosis, other menopausal symptoms)
- Risk of ovarian cancer with removal of both ovaries is reduced, but not eliminated

If planning a hysterectomy and/or having ovaries removed, please initial /date: _____

Transfusion of blood or blood products

Risk of infection [includes but not limited to Hepatitis B (1:50,000), Hepatitis C (1:3,300), HIV (Human Immunodeficiency Virus) (1:150,000-1:1,000,000), CMV (Cytomegalovirus)]

Risk of transfusion reaction (1:6000): chills, fever, chest/flank pain, nausea, shock, problems with clotting

Please initial /date: _____

Surgery has the potential to change the vagina. Surgery can infrequently alter the vagina's opening, its caliber (width), and its length. As a result, there is a risk that you may perceive the vagina to be tight (Symptoms: pain, painful intercourse, scars and bands inside the vagina). This may require treatment, including office therapies and/or additional surgery(s).

Please initial /date: _____

I understand that the explanation of **the risks and consequences that I have received is not exhaustive** and that other, more remote risks and consequences may arise. I have been advised that these, more remote risks and consequences, will be explained to me upon request.

Please initial /date: _____

Although complications are infrequent, **it is not realistic to assume that you will not have a complication** with any procedure in your lifetime that you elect to have. It is you and/or your insurance company's financial responsibility to pay for charges/fees related to treatment of a complication. It is a contract violation of your insurance company for your doctor to waive any fees / charges during treatment of a complication.

Please initial /date: _____

It is possible that during the course of the procedure, unforeseen conditions may be involved that necessitate an extension of the original procedure(s) or different procedure(s) than those described by my doctor. I therefore authorize and request that my doctor, his/her assistants, or designees perform such surgical or medical procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this paragraph shall extend to treating all conditions that require treatment and are not known to my doctor or me at the time of the operation or procedure is commenced.

Please initial /date: _____

I acknowledge that I have received **no guarantee** concerning the medical or surgical procedure to which I am consenting.

Please initial /date: _____

Since this is elective surgery I have had the chance to research other surgeons and surgical approaches. The options of care have been fully discussed such as outside consultations and surgery, no surgery, expectant management (wait and see), medical management, or to proceed with the agreed upon surgery. I have chosen to proceed with the elective surgery willingly and without hesitation at the time frame of my choosing.

Please initial /date: _____

PLEASE USE THIS SPACE TO LIST ANY PERSONAL CONCERNS THAT YOU WANT US TO ADDRESS AT YOUR PRE-OPERATIVE VISIT:

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I acknowledge that I have read this document in its entirety and that I fully understand it and that the blank space above has been either completed by me or left blank at my discretion prior to my signing.

Patient Signature:	Date:
Witness Signature:	Date:

Please initial the document at any time at your convenience, but wait to sign it until your next office visit.