

## INFORMED CONSENT AND REQUEST FOR HYSTERECTOMY

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

PATIENT'S NAME \_\_\_\_\_

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring the procedure is: \_\_\_\_\_  
\_\_\_\_\_

2. The nature of the procedure is that a hysterectomy would involve removal of the uterus through an incision into the abdomen or through the vagina, or may involve using a laparoscope in combination with these incisions. Complete or partial removal or repair of other abdominal or pelvic organs such as ovaries, fallopian tubes, appendix, bladder, rectum and vagina may be done along with the hysterectomy.

3. The purpose of the procedure is: \_\_\_\_\_  
\_\_\_\_\_

#### 4. MATERIAL RISKS OF THE PROCEDURE

As a result of this procedure being performed, there may be material risks of:

Infection, Allergic Reaction, Disfiguring Scar, Severe Loss of Blood, Loss or Loss of Function of any Limb or Organ, Paralysis or Partial Paralysis, Paraplegia or Quadriplegia, Brain Damage, Cardiac Arrest or Death.

5. In addition to these material risks, there may be other possible risks involving this procedure including but not limited to:

- a. possible injury to bowel, bladder, ureter or other pelvic or abdominal structures;
- b. possible fistula formation (an opening between bowel, bladder, ureter, vagina and/or skin) caused by an injury to the bowel, bladder, or ureter;
- c. possible formation of blood clots;
- d. possible blood loss necessitating transfusion which carries the risk of exposure to AIDS, hepatitis, and other infectious diseases;
- e. possible need for immediate surgery or other additional surgery, which might include a colostomy;
- f. possible hernia at the incision site;
- h. possible emboli (clots of blood and other material) that may travel to other parts of the body;
- g. possible need for hormones or other drug therapy;
- h. possible pelvic pain due to adhesions, scar tissue, or residual ovary.

6. The likelihood of success of the above procedure is: ( )good; ( )fair; ( )poor.

7. The practical alternatives to this procedure are: hormone or drug therapy; use of radiation and/or x-ray therapy; other medical or surgical procedures; do nothing and accept the consequences of the patient's condition.

8. If the patient chooses not to have the above procedure, the prognosis (predicted future medical condition) is: \_\_\_\_\_

I understand that the hysterectomy must be considered permanent and not reversible. I understand that I will not be able to become pregnant or bear children if I undergo this procedure. I understand that I have the right to seek consultation from a second physician.

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the above procedure.

I understand the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and other treatment or courses of treatment relating to the diagnosis or procedures described herein.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTION AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW RELATING TO THE PROCEDURE DESCRIBED HEREIN.**

I voluntarily consent to allow Dr. \_\_\_\_\_ or any physician designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Person Giving Consent

Relationship to patient if not the patient:  
\_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

Patient unable to sign because: \_\_\_\_\_

Additional materials used, if any, during the informed consent process for this procedure: