

DISCLOSURE AND CONSENT FOR HYSTERECTOMY

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

NOTICE: Refusal to consent to a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect your right to future care or treatment.

I (we) voluntarily request Dr. _____, as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me (us) as: _____

_____.

I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: _____

_____.

I (we) understand that a hysterectomy is a removal of the uterus through an incision in the lower abdomen or vagina. I (we) also understand that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina.

I (we) understand that the hysterectomy is permanent and not reversible. I (we) understand that I will not be able to become pregnant or bear children. I (we) understand that I have the right to seek consultation from a second physician.

I (we) understand that my physician may discover other or different conditions which require additional different procedures than those planned. I (we) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures, which are advisable in their professional judgment.

I (we) (do) (do not) consent to the use of blood and blood products as deemed necessary. I (we) understand that the following risks and hazards may occur in connection with the use of blood and blood products:

1. Serious infection including but not limited to Hepatitis and HIV which can lead to organ damage and permanent impairment.
2. Transfusion related injury resulting in impairment of lungs, heart, liver, kidneys, and immune system.
3. Severe allergic reaction, potentially fatal.

I (we) understand that no warranty or guarantee has been made to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures are the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure (check applicable procedure):

ABDOMINAL HYSTERECTOMY 1. Uncontrollable leakage of urine. 2. Injury to the bladder. 3. Sterility. 4. Injury to the tube (ureter) between the kidney and the bladder. 5. Injury to the bowel and/or intestinal obstruction.	VAGINAL HYSTERECTOMY 1. Uncontrollable leakage of urine. 2. Injury to the bladder. 3. Sterility. 4. Injury to the tube (ureter) between the kidney and the bladder. 5. Injury to the bowel and/or intestinal obstruction. 6. Completion of operation by abdominal incision.
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† For laparoscopically assisted hysterectomy, the additional risks include: damage to intra-abdominal structures (e.g. bowel, bladder, blood vessels, or nerves); intra-abdominal abscess and infectious complications; trocar site complications (e.g., hematoma/bleeding, leakage of fluid, or hernia formation); conversion of the procedure to an open procedure; cardiac dysfunction.

† If a power morcellator is used, the additional risks include: if cancer is present, increased risk the cancer may spread; increased risk of damage to adjacent structures.

ADDITIONAL COMMENTS: _____

I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of no treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (we) certify this form has been fully explained to me (us), that I (we) have read it or have had it read to me (us) , that the blank spaces have been filled in, and that I (we) understand its contents.

NAME OF PHYSICIAN EXPLAINING PROCEDURE:

NAME OF PERSON PROVIDING MATERIALS:

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

DATE: _____ TIME: _____ A.M./P.M.

WITNESS:

Signature

Name (Print)

Address (Street or P.O. Box)

City, State, Zip Code