

# Palm Beach Obstetrics & Gynecology, PA

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Lake Worth, FL 33461

4631 N Congress Avenue  
West Palm Beach, FL 33407

## INFORMED CONSENT AND REQUEST FOR SURGICAL PROCEDURE

Do not sign this form until you have read it and fully understand its contents.

Patient Name: \_\_\_\_\_

I acknowledge and understand that the following procedures have been described to me to my satisfaction:

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The following has been explained to me in layman's terms and I understand that the procedure entails:

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1. The purpose of the procedure is :

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## 2. MATERIAL RISKS OF THE PROCEDURE

The above is a common procedure that is safely performed in thousands of patients annually. However, it is still major surgery and complications may occur. As a result of this procedure being performed, there is a risk of : pain, bleeding, infection, damage to the bladder, bowel or blood vessels, and allergic reactions to medications.

There are other, rare complications that are possible. These include:

- Possible injury to the ureter or other pelvic organs.
- Possible fistula formation (An opening between the bladder and vagina, or between the rectum and vagina)
- Possible need for a second operation to correct a problem.
- Possible colostomy.
- Possible need for hormone replacement or other therapies.
- Possible blood loss that requires transfusion and its small risk of exposure to infectious diseases such as Hepatitis and AIDS.
- Possible pelvic pain due to adhesions or scar tissue.
- Possible formation of blood clots or embolus (blood clots that travel to other parts of the body).
- Possible hernia at the incision site.
- Damage or loss of function of a limb or organ. Paralysis, cardiac arrest or death.
- If the procedure in an endometrial ablation, I understand that this procedure may cause

- infertility, and that pregnancy needs to be avoided since serious complications can occur.
- If the procedure is a tubal ligation, I understand that there is a 1 in 300 chance of failure.

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

4. The practical alternatives to this procedure include:

- a. Do nothing and accept the consequences of the present condition.
- b. Hormone or other drug therapy
- c. Use of radiation/X-ray therapy.
- d. Other medical or surgical procedures such as: \_\_\_\_\_

5. If the patient chooses not to have the above procedure, the problem could worsen and cause:

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- I understand that I have the right to seek consultation from a second physician.
  - I understand that I should not eat or drink anything after midnight the night before surgery. I also agree to stop using products containing aspirin, Advil, Motrin or other similar over the counter pain medications a week before surgery. I will notify the office if I develop a cold, fever, sore throat or any other unusual symptom.
  - I understand that the physicians', medical personnel and other assistants at the hospital will rely on statements made by the patient as well as the patient's medical history to determine the proper procedure and treatment during her hospitalization.
  - I understand that the practice of medicine is not an exact science, and that no guarantee or assurances can be given 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 at this time. I consent to let the doctor make decisions regarding the performance of such procedures.
  - I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and other treatments relating to the diagnosis or procedures described here.

By signing this form, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. I understand that I can call or return to the office at any time to ask for more information from the doctor or his staff.

I consent to allow Dr. \_\_\_\_\_ and all the medical personnel under his supervision and control, to perform the procedure(s) described in this consent form.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date