

Chapter 1: Hysterectomy

Consent For Abdominal Hysterectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained the need for hysterectomy for the following indication /s

Text box-----

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment, have been discussed with me and I have opted for this modality of treatment.

I understand that this will lead to stoppage of menstruation and inability to have babies but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries have been discussed with me

I understand that the procedure involves removal of uterus through abdominal incision(cut).

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system which is minimized by routine use of antibiotics.
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Delayed wound healing, keloid (thick scar) formation

Uncommon risks:

- Accidental Injury to the urinary bladder / intestine (1%) / ureter/ major blood vessel– in such event extra procedure will be required to repair the same, by appropriate specialist.

- Damage to the Bowel (0.04%), urinary system (0.7%) and/ or disturbance to bladder function
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (< 0.2 %)
- Risk of blood clots (0.4 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)
- All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical co morbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal /conservation of one /both ovaries.

I consent for removal of one /both tubes.

Any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Sub-Total Abdominal Hysterectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained the need for hysterectomy for the following indication /s

Text box-----

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that this will lead to stoppage of menstruation / minimal bleeding during menses and inability to have babies but other symptoms not related to uterus will not alter.

I understand that the mouth of the uterus (cervix) will be left behind and that there is need for regular follow-up for PAP smear

The pros and cons of removal / conservation of ovaries has been discussed with me

I understand that the procedure involves removal of uterus through abdominal incision.

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system which is minimized by routine use of antibiotics.
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Delayed wound healing, keloid (thick scar) formation

Uncommon risks:

- Accidental Injury to the urinary bladder / intestine (1%)/ ureter/ major blood vessel—in such event extra procedure will be required to repair the same, by appropriate specialist.

- Damage to the Bowel (0.04%), urinary system (0.7%) and/ or disturbance to bladder function
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (< 0.2 %)
- Risk of blood clots (0.4 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical co morbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal /conservation of one /both ovaries.

I consent for removal of one /both tubes.

Any extra procedures that may become necessary during the procedure

DocumentUltimate

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Vaginal Hysterectomy with Pelvic floor repair

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I understand that I have vaginal/uterine prolapse and vaginal hysterectomy and pelvic floor repair is done to relieve the same by reconstruction of vaginal walls, replacing the bowel and bladder in their correct position, with or without removal of uterus.

The other medical and less invasive procedures and alternative therapies (physiotherapy and ring pessary), including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that the removal of uterus will lead to stoppage of menstruation and inability to have babies (in premenopausal women) but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries have been discussed with me.

I understand that the procedure involves removal of uterus through vaginal route / may involve assistance with abdominal route / laparoscopic surgery

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- Bruising and Post-operative shoulder discomfort is short lived
- The surgery carries a risk of infection of wound /urinary system which is minimized by routine use of antibiotics
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of urination for a few months
- Delayed wound healing, keloid (thick scar) formation

Uncommon risks:

- Accidental Injury to the urinary bladder / intestine (1%)—in such event extra procedure will be required to repair the same, by appropriate specialist.
- Damage to the Bowel (0.04%), urinary system (0.7%) and/ or disturbance to bladder function
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (0.2 %)
- Risk of blood clots (0.4 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)
- Failure to achieve the desired result: recurrence of prolapse.
- All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical co morbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal / conservation of one /both ovaries.

I consent for removal / conservation of one /both tubes.

Any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Non-Descent Vaginal Hysterectomy

DocumentUltimate

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure:

I have been explained the need for hysterectomy for the following indication/s

Text box-----

The other medical and less invasive procedures and alternative therapies (physiotherapy and ring pessary), including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that the removal of uterus will lead to stoppage of menstruation and inability to have babies (in premenopausal women) but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries have been discussed with me.

I understand that the procedure involves removal of uterus through vaginal route / may involve assistance with abdominal route / laparoscopic surgery

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system which is minimized by routine use of antibiotics
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of urination for a few months
- Delayed wound healing, keloid (thick scar) formation

Uncommon risks:

- Accidental Injury to the urinary bladder / intestine (1%)—in such event extra procedure will be required to repair the same, by appropriate specialist.
- Damage to the Bowel (0.04%), urinary system (0.7%) and/ or disturbance to bladder function
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (0. 2 %)
- Risk of blood clots (0.4 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)
- Failure to achieve the desired result: recurrence of prolapse.

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical co morbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal / conservation of one /both ovaries.

I consent for removal / conservation of one /both tubes.

Any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Laparoscopy Assisted Vaginal Hysterectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained the need for hysterectomy for the following indication/s

Text box-----

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that this will lead to stoppage of menstruation and inability to have babies but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries has been discussed with me

I understand that the procedure involves removal of uterus through abdominal incision by laparoscopy

I understand that the procedure will be done under suitable anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system (10%) which is minimized by routine use of antibiotics.
- Bloating feeling in abdomen and shoulder pain
- Excessive bleeding may necessitate blood transfusion (1.5-3%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Delayed wound healing, keloid (thick scar) formation

Uncommon risks:

- Accidental Injury to the urinary bladder /ureter (1%) intestine (2%)—in such event extra procedure will be required to repair the same, by appropriate specialist.
- Damage to blood vessels and nerves (<1%)
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (< 0.2 %)
- Risk of blood clots (<1 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)
- Conversion to open surgery (1-25%)

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical co morbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal / conservation of one /both ovaries.

I consent for removal / conservation of one /both tubes.

Any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent For Radical Abdominal Hysterectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor:

Date of obtaining consent:

Date of scheduled procedure:

I have been explained the need for hysterectomy for the following indication/s

Text box-----

I have been explained the need for removal of womb, cervix, Fallopian tubes and ovaries, part of the vagina and lymph glands. This operation is done for cancer Text box

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that this will lead to stoppage of menstruation and inability to have babies but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries has been discussed with me

I understand that the procedure involves removal of uterus through abdominal incision.

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system which is minimized by routine use of antibiotics. (10-20%)
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Delayed wound healing, keloid (thick scar) formation
- Urinary dysfunction may last for 12 months in 70%
- Inability to do the intended procedure in 1 – 2 %

Uncommon risks:

- Accidental Injury to the urinary tract (2%)—in such event extra procedure will be required to repair the same, by appropriate specialist.
- Damage to the Bowel (0.04%),
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (10% %)
- Risk of blood clots (5%) in the veins of the legs which is reduced by appropriate measures
- Collection of Lymph in pelvis (lymphocyst 2-3%)

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical comorbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

DocumentUltimate **Consent For Laparoscopic Radical Hysterectomy**

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure:

I have been explained the need for hysterectomy for the following indication/s

-----Text box-----

I have been explained the need for removal of womb, cervix, Fallopian tubes and ovaries, part of the vagina and lymph glands. This operation is done for cancer...text box.....

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that this will lead to stoppage of menstruation and inability to have babies but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries has been discussed with me

I understand that the procedure involves removal of uterus through abdominal incision.

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system which is minimized by routine use of antibiotics. (10-20%)
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Bloating feeling and shoulder pain for a few days.
- Delayed wound healing, keloid (thick scar) formation
- Urinary dysfunction may last for 12 months in 70%
- Inability to do the intended procedure in 1 – 2 %.

Uncommon risks:

- Accidental Injury to the urinary tract (2%)—in such event extra procedure will be required to repair the same, by appropriate specialist
- Damage to the Bowel (0.04%),
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (10% %)
- Risk of blood clots (5%) in the veins of the legs which is reduced by appropriate measures
- Collection of Lymph in pelvis (lymphocyst 2-3%)

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical comorbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: **drop list of our list of doctors**

Name, Relationship and Signature of the witness:

Consent For Laparoscopic Hysterectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained the need for hysterectomy for the following indication/s

-----Text box-----

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that this will lead to stoppage of menstruation and inability to have babies but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries has been discussed with me

I understand that the procedure involves removal of uterus through abdominal incision by laparoscopy

I understand that the procedure will be done under suitable anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system (10%) which is minimized by routine use of antibiotics.
- Excessive bleeding may necessitate blood transfusion (1.5-3%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months

- Bloating feeling and shoulder pain for few days
- Delayed wound healing, keloid (thick scar) formation

Uncommon risks:

- Accidental Injury to the urinary bladder /ureter (1%) intestine (2%)—in such event extra procedure will be required to repair the same, by appropriate specialist.
- Damage to blood vessels and nerves (<1%)
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (< 0.2 %)
- Risk of blood clots (<1 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)
- Conversion to open surgery (1-25%)

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical comorbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal /conservation of one /both ovaries.

I consent for removal of one /both tubes.

Any extra procedures that may become necessary during the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent For Vaginal Hysterectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained the need for hysterectomy for the following indication/s

-----Text box-----

I understand that I have vaginal/uterine prolapse and vaginal hysterectomy done to relieve the same by reconstruction of vaginal walls, replacing the bowel and bladder in their correct position.

The other medical and less invasive procedures and alternative therapies (physiotherapy and ring pessary), including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that removal of uterus will lead to stoppage of menstruation and inability to have babies but other symptoms not related to uterus will not alter.

The pros and cons of removal / conservation of ovaries have been discussed with me.

I understand that the procedure involves removal of uterus through vaginal route / may involve assistance with abdominal route / laparoscopic surgery

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system/ uterus, which is minimized by routine use of antibiotics
- Excessive bleeding may necessitate blood transfusion (1.5%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Delayed wound healing, keloid (thick scar) formation.

Uncommon risks:

- Accidental Injury to the urinary bladder / intestine (1%)—in such event extra procedure will be required to repair the same, by appropriate specialist.
- Damage to the Bowel (0.04%), urinary system (0.7%) and/ or disturbance to bladder function
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (0. 2 %)

- Risk of blood clots (0.4 %) in the veins of the legs which is reduced by appropriate measures
- Early menopause (4 %)
- Failure to achieve the desired result: recurrence of prolapse.

All operations carry some risk of death (approximately 1 in 4000)

I understand that, in the presence of my pre existing medical comorbidity, the additional risks involved which are the following but not limited to.....text box.....

I also understand that, in view of my past surgical history, I may have adhesions, and the surgery may get technically more difficult and again there may be a risk of bowel or bladder injury which may require additional surgical intervention.

Additional remarkstext box.....

Wishes of the patient –

I consent for removal/ conservation of one/ both ovaries.

I consent for removal/ conservation of one / both tubes

Any extra procedures that may become necessary during the procedure

DocumentUltimate

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Chapter 2: Obstetrics

Obstetrics Consent Form

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Vaginal Birth:

The nature of the procedure is the delivery of the infant through the birth canal with the possible use of forceps or vacuum extraction.

An episiotomy (an enlarging of the vaginal opening in the space between the vagina and the rectum) may be performed as part of a vaginal delivery.

Anesthesia, if required may include IV pain medications, epidural, spinal, pudendal, local or general.

Only about 50 % of first - time mothers experience an uncomplicated spontaneous vaginal birth.

Risks are higher than threshold in women over 35 years in their first pregnancy and in those with a combination of age over 30 years and BMI over 30.

Overall, only 75% of the women are able to achieve vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia will be necessary.

Risks at the Time of Delivery:

Vaginal Birth-

Vaginal birth causes extreme pressures on the tissues and organs of the pelvis. This can result in tears of the vagina (5-6% third degree perineal tear, 40% - some degree tear), rectum, cervix, or uterus which can later cause urinary or fecal incontinence, prolapse of the uterus and vaginal walls, and/or pain with intercourse.

Occasionally patients develop a large bruise or hematoma of the pelvis which may require surgery to drain. / vaginal pack.

Sutures used for repair of vaginal tears or episiotomies usually heal quickly but on occasion poor healing or infection may require prolonged treatment. Rarely a fistula (hole) can develop between the vagina and rectum or the vagina and bladder.

Shoulder Dystocia

During Vaginal Birth- Rarely after delivery of the baby's head the shoulders may become entrapped behind the pubic bone and can be difficult to deliver. This condition is called "shoulder dystocia" and is very difficult to predict. Even with proper use of maneuvers to deliver the shoulders, nerve injuries to the baby's neck and upper extremities are possible. Specific risks or complications associated with these maneuvers include the need for

emergency cesarean section, uterine rupture, trauma to the fetus and maternal and/or fetal death.

Forceps and Vacuum Devices:

15% of vaginal deliveries are Operative (instrumental) deliveries. Occasionally vaginal and cesarean deliveries are assisted by the use of forceps or a vacuum apparatus which can be life saving for the baby.

These devices when properly applied usually cause no injuries to the fetus but often leave a mark on the baby that is temporary.

In rare instances, even with proper use injuries to the baby can occur. Risks include cephalohematoma (swelling under the skin with bruising of the head), cranial (skull) fractures, facial bruises, intraventricular (brain) hemorrhage, retinal hematoma (bruising of portion of the eye) and facial nerve palsy.

Cesarean Section

May be scheduled or required for many reasons. These reasons include, but are not limited to having a previous Cesarean Section, the baby may not tolerate labor and have drops in the heart rate, or the baby may not be head first which is called “malposition,” or the baby may not be descending through the birth canal properly. Anesthesia may include epidural, spinal, or general anesthesia.

General Surgical Risks

There are risks attendant to the performance of any surgical procedure, such as loss of blood, infection, the formation of blood clots which may break loose and go to the lung or other areas, (greatly reduce with appropriate measures and medication) ,

Rarely reaction to anesthesia or other medications, cardiac and/or respiratory arrest, complete or partial paralysis, brain damage, injury to internal organs, death and others as well as the specific risks listed above. At times a return trip to the operating room may be required to repair injuries, control bleeding, drain hematomas or abscesses, to cut adhesions, or other reasons.

Uterine Atony (8%) – The uterus may not contract properly after vaginal or cesarean birth causing excessive bleeding or hemorrhage. This can usually be controlled by medications and/or uterine massage. Blood transfusion may be required (1%).

Retained Placenta - The placenta (afterbirth) usually is delivered in one piece but on occasion fragments of the placenta may be retained in the uterus during vaginal or cesarean birth which can cause bleeding, infection, and may require D&C, hysterectomy, and blood transfusions.

Uterine Rupture -In case of previous uterine surgery, there may be an increased risk of uterine rupture prior to or during delivery.

Emboli – During vaginal or cesarean birth the amniotic fluid which surrounds the baby may enter the mother’s circulation (amniotic fluid embolus) or a blood clot may form in a vessel, come loose and go to the lung (pulmonary embolus). These are extremely y rare but serious complications which cannot be predicted and which cannot be prevented may result in maternal and/or fetal death.

Maternal and/or Fetal Death - Rarely occurs prior to or during vaginal or cesarean delivery.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to allow Dr. _____ **drop list** _____ or any Obstetrician designated or selected by him or her and all medical personnel under the direct supervision and control of such Obstetrician to perform the procedures described.

I and my family members have understood about my labor management and we have been explained the above in _____ **drop list – English, Hindi, Kannada, Tamil, Telugu, Malayalam, Gujarati** _____ language.

Patient's Name:

Signature:

Husband's / Relative's
Name:

Signature:

Registrar's/ Duty doctor's
Name:

Signature:

Consultant's Name:

Signature:

Consent Form for Perineal Tear Repair

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Intended benefits

To attempt to restore anorectal and perineal anatomy, facilitate wound healing and reduce the risk of anal incontinence. The risks quoted below might be linked to sphincter (anal muscle) damage rather than the repair and these are likely to be significantly higher if the trauma is not repaired.

Frequent risks

- Fear, difficulty and discomfort in passing stools in the immediate postnatal period
- Migration of suture material requiring removal
- Granulation tissue formation
- Fecal urgency, 26/100 (very common)
- Perineal pain and dyspareunia, 9/100 (common)
- Wound infection, 8/100 (common)
- Urinary infection. 2 of 5

Serious and frequently occurring risks

- Incontinence of stools and/or flatus.

Uncommon:

- Delivery by caesarean section in future pregnancies may be recommended if symptoms of incontinence persist or investigations suggest abnormal anal sphincter structure or function.

Rare:

- Hematoma.
- Consequences of failure of the repair requiring the need for further interventions in the future such as secondary repair or sacral nerve stimulation.

Very rare:

- Rectovaginal fistula.

Any extra procedures which may become necessary during the procedure

- Blood transfusion.
- Rarely, a vaginal pack is required if hemostasis cannot be achieved.

I have understood the problem and the need to undergo the surgical repair

Name and signature of Patient: **Auto entry for name**

Name and Signature of the Doctor: **drop list of our list of doctors**

Name, Relationship and Signature of the witness:

Consent For Caesarean Section

Patient Name: _____ Age: _____

W/o or D/o: _____

IC No. _____

Doctor: _____

Date of obtaining consent: _____

I have been explained that the caesarean section is needed at this time to secure the safe and quick delivery of the baby/babies, in order to preserve maternal and baby/ies health at optimal level.

I also understand that refusal of caesarean section can be detrimental to my health/ my baby's health.

I have been explained the reason / reasons for caesarean section namely

.....Text box.....

Alternate method has been explained to me that -----Text box-----

I understand that the baby / babies will be delivered by abdominal route through an incision (cut) on the lower abdomen and on the uterus.

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand the following are the:

Commonly occurring risks at the time of surgery/immediate post-operative period.

- Use of forceps/vacuum to deliver the head
- The surgery carries a risk of infection of wound (6%), urinary system/ uterus, which is minimized by routine use of antibiotics.
- Excessive bleeding may necessitate appropriate medication and blood transfusion. (0.5-1%)
- Risk of blood clots (<1%) in the veins of the legs which can be minimized by appropriate measures.
- Persistent wound and abdominal discomfort for a few months-9%

Uncommon risks:

- Accidental Injury to the urinary bladder / intestine (<1%)—in such an event, extra procedure will be required to repair the same, by appropriate specialist.
- Sometime excessive bleeding may necessitate other measures to control the bleeding like -packing of uterus / surgery on major vessels as lifesaving procedure. (0.5%)
- Need for surgery at a later date, admission to intensive care unit. (<1%)
-

Rarely

- Hysterectomy (removal of uterus) as lifesaving procedure. (0.7%)

Very rarely

- Death (1:12,000)-depends on the indication for caesarean section.

Future pregnancy:

- Increased risk of repeat caesarean section in subsequent pregnancies (25%)
- Increased risk in subsequent pregnancies of placenta previa, placenta accreta. (adherent placenta), rupture uterus. (<1%).

Wishes of the patient –My doctor may need to do other procedures during the Cesarean Section. This could happen if he or she finds an unexpected condition. If my doctor feels it's needed, I agree to these added procedures. These would be done to avoid the risks of having a second surgery or procedure. -----

Additional remarkstext box.....

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

DocumentUltimate

Informed Consent for the Management of Post-Partum Hemorrhage (PPH)

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of Obtaining consent: _____

What is PPH?

It is normal to bleed from vagina after the birth of the baby. This blood mainly comes from uterus where the placenta was attached, but it may also come from any cuts and tears caused during the birth. Bleeding is usually heaviest just after birth and gradually becomes less over the next few hours. The bleeding will reduce further over the next few days.

Sometimes bleeding during or after birth is heavier than normal which is called post-partum hemorrhage.

PPH can be primary or secondary:

Primary PPH is when the loss is 500ml (a pint) or more of blood within the first 24 hours after the birth of the baby. Primary PPH can be minor, where the loss is 500–1000ml (one or two pints), or major, where it is more than 1000ml (more than two pints).

Secondary PPH occurs when there is abnormal or heavy vaginal bleeding between 24 hours and 12 weeks after the birth.

Primary PPH accounts for 28% of maternal deaths in developing countries. It happens in 1:1000 deliveries in developing countries and 1 :100000 in developed countries & even there 1:1000 in people who refuse blood transfusion.

Risk factors for PPH are: Maternal obesity, large baby, advanced maternal age, multiple pregnancies, prolonged labor, high blood pressure, fibroids, anemia, instrumental delivery etc.

Most women do not have identifiable risk factors.

The drugs that are given to prevent bleeding only help in 40 % of the cases.

The doctor may: • massage the womb through the abdomen, and sometimes vaginally, to encourage it to contract • give injections to help the womb contract • put a catheter (tube) into the bladder to empty it as this may help the womb contract • put a drip to give some fluids after taking some blood for testing • check to make sure that all of the placenta has come out. If there are any missing pieces still inside the womb, they may have to be removed; this is usually done in an operating theatre under anesthetic • examine to see whether any stitches are required.

What happens if there is continued heavy bleeding?

If heavy bleeding continues and the loss is more than 1000ml (two pints) of blood, a team of senior hospital staff will be involved in the care. Medications may be given as an injection or via the back passage to help stop the bleeding., oxygen via a facemask and a second drip for extra intravenous fluids, blood transfusion or medication to help blood to clot. If the bleeding continues, patient may be taken to the operating theatre to find the cause of the hemorrhage under anesthesia.

There are several procedures the doctors might use to control the bleeding:

- A special 'balloon' /instrument may be inserted into the womb to put pressure on the bleeding blood vessels. This is usually removed the following day.
- An abdominal operation (laparotomy) may be performed to stop the bleeding.

Procedures done are B-Lynch procedure, step wise ligation (blockage) of blood vessels feeding the uterus, uterine packing, suturing of any internal tears etc.

- Very occasionally, a hysterectomy (removal of the womb) is necessary to control the heavy bleeding.
- In some situations, where the facilities are available, a procedure called uterine artery embolization may be performed to help stop the bleeding. This procedure is done by a specially trained radiologist (X-ray doctor). It involves injecting small particles via a thin tube (catheter) under X-ray guidance to block the blood supply to the womb.

The family members will be kept informed of the condition of the patient from time to time.

Once the bleeding is under control, the patient will either be transferred back to the labor ward or to an intensive care or high-dependency unit to monitor closely until the patient is well enough to go to the postnatal ward.

The patient may be offered daily blood-thinning injections (heparin) for 5 days and compression stockings to wear for 10 days after the birth of the baby. This is because after a PPH there is increased risk of developing blood clots in legs or lungs.

The patient may have to stay longer in hospital than usual for monitoring and observations. When patient goes home she may still be tired and anemic, and may need treatment with iron. It may take a few weeks before she makes a full recovery.

Additional remarkstext box.....

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Manual Removal of Placenta

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of Obtaining consent: _____

In 97% of deliveries, the placenta (afterbirth) comes away easily from the inside of the uterus, once it contracts after the birth of the baby.

Doctors can offer to help separation of the placenta include:

- ensuring that the mother's bladder is empty (if it is full, this tends to prevent the uterus from contracting down firmly);
- offering the baby, the breast (as this releases oxytocin, which makes the uterus contract);
- massaging the top of the uterus through the abdominal wall (your tummy).
- The active management procedure includes injection of drugs to speed up the natural process

The third stage usually lasts between 30 and 60 minutes after the baby has been born. If the placenta has not been pushed out within that hour it is said to be 'retained' and help may be needed to remove it.

A retained placenta may be due to:

- (i) the uterus not contracting well after the baby is born so that the placenta remains fully, or partially attached inside the uterus.
- (ii) the umbilical cord snapping.
- (iii) the placenta had attached abnormally deeply (placenta accreta, placenta increta or placenta percreta) and could not separate. These conditions are rare (less than 1 in 2500 pregnancies) and are not discussed further in this leaflet.

It is usual for there to be some bleeding from the mother's vagina after her baby has been born. S/he may also call for a theatre team, as it is usual to offer to take the mother to theatre for a careful examination under anesthetic if the placenta has not been delivered.

If you decide to go to theatre, the anesthetist will visit you and discuss what type of anesthetic is recommended: if you have had an effective epidural, this can be 'topped-up' and used, or the anesthetist may recommend a spinal anesthetic. With either of these, you will remain conscious but comfortable. Sometimes, a general anesthetic is recommended, or requested by the mother.

Neither your birthing partner nor your baby will be taken into theatre.

If the placenta is 'sitting in the cervix', it can be easily pulled down the vagina. If it is still up in the cavity of the uterus, the obstetrician will place their fingers inside the uterus to detach the placenta and remove it. Their other hand is placed firmly on your tummy to steady the top of the uterus whilst this maneuver is completed. If you had any tears or an episiotomy, these will be stitched before you leave theatre. It is normal for you to have a drip with oxytocin for about four hours after this procedure, and for you to be prescribed antibiotics. The first dose is given whilst you are in theatre.

Additional remarkstext box.....

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent For The Procedure Dilatation And Evacuation

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

I, being over the age of 18 years and in suitable state authorize Dr____(drop list)____ and or /such associates and assistants as may be designated by her to perform the above said procedure.

I am aware of the reasons for the selected modality **—text box-----**

I am aware of the alternative methods **----text box-----**

I am also aware of the outcome of the said procedure in terms of risks (infection, perforation, bleeding), success rate as well as failure to achieve intended result.

DocumentUltimate

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Additional remarks **.....text box.....**

Name and signature of Patient: **Auto entry for name**

Name and Signature of the Doctor: **drop list of our list of doctors**

Name, Relationship and Signature of the witness:

Consent for The Procedure – Cervical Cerclage

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I, authorize Dr. -----(drop list)----and or /such associates and assistants as may be designated by her to perform the above said procedure.

I am aware of the reasons for the selected modality (type of cerclage-----text box-----)

I am aware of the alternative methods ---text box-----

I am also aware of the outcome of the said procedure in terms of risks (infection. Bleeding, membrane rupture, injury to cervix, injury to bladder),

I am aware that the success rate is 85%.

Additional remarkstext box.....

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

CHAPTER 3 : Gynecology

Consent For Bilateral Laparoscopic Tubectomy /Tubal Ligation

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained that the Fallopian tubes will be blocked by ----text box--- (describe the method). It is done by insertion of a small telescope put into abdomen through a small cut (one in the navel and one in the lower abdomen)

I understand that the procedure will be done under suitable anesthesia, which is either general /regional anesthesia.

I understand,

- That the aim of the operation is to prevent pregnancy and it might not be possible to reverse the effects of the operation.
- However, if one wishes to conceive for any reason later– tubal recanalization has to be done (which is another operation) or one needs to undergo IVF +ET (test tube baby)
- Other alternative permanent method of sterilization (vasectomy for my partner/husband) and reversible methods of contraception have been explained to me and I have opted for laparoscopic tubal sterilization.
- Sometimes the procedure may not be able to be completed as planned by laparoscopy due to various reasons. In such an event, my doctor will have to open my abdomen by a cut and complete the procedure.

I understand that the following side effects /complications can occur

- The operation cannot be guaranteed 100% to make me sterile. On the average 4 out of 1,000 women get pregnant after the operation.
- Possibility of future pregnancy in fallopian tube.
- Overall complication rate is 0.5% - pain, bleeding, infection, bloated feeling and injury to internal organs.

Additional remarkstext box.....

I give my consent to perform the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Bilateral Abdominal Tubectomy /Tubal Ligation

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I have been explained that the Fallopian tubes will be blocked or cut by -----text box-----
---It is done by a small cut in the lower abdomen.

I understand that the procedure will be done under suitable anesthesia, which is either general or regional anesthesia.

I understand,

- That the aim of the operation is to prevent pregnancy and it might not be possible to reverse the effects of the operation.
- However, if one wishes to conceive for any reason later– tubal recanalization has to be done (which is another operation) or one needs to undergo IVF +ET (test tube baby)
- Other alternative permanent method of sterilization (vasectomy for my partner/husband) and reversible methods of contraception have been explained to me and I have opted for the above procedure.

I understand that the following side effects /complications can occur

- The operation cannot be guaranteed 100% to make me sterile. On the average 4 out of 1,000 women get pregnant after the operation.
- Possibility of future pregnancy in fallopian tube.
- Overall complication rate is less than 1% - pain, bleeding, infection, bloated feeling and injury to internal organs.

Additional remarkstext box.....

I give my consent to perform the procedure

Name and signature of Patient: _____

Name and Signature of the Doctor:

Name and Signature of the witness:

Consent for the Procedure Dilatation and Curettage

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I, authorize Dr. ---(**drop list**)---and or /such associates and assistants as may be designated by her to perform the above said procedure.

I am aware of the reasons for the selected modality ---(**text box**)---

I am also aware of the outcome of the said procedure in terms of risks (infection, perforation, bleeding), success rate as well as failure to achieve intended result.

Additional procedures if needed (-----**text box**-----)

Additional remarks**text box**.....

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Name and signature of Patient: **Auto entry for name**

Name and Signature of the Doctor: **drop list of our list of doctors**

Name, Relationship and Signature of the witness:

Consent for The Procedure – Bartholin Abscess Drainage

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I authorize Dr. -----(drop list)-----and or /such associates and assistants as may be designated by her to perform the above said procedure.

I am aware of the reasons for the above said procedure.

I am aware of the alternative methods like treatment with antibiotics and waiting

I am also aware of the outcome of the said procedure in terms of risks (spread of infection, septicemia, Bleeding, delayed wound healing and recurrence 5 – 15%).

Additional remarkstext box.....

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for The Procedure – Vulvar Abscess Drainage

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I authorize Dr. ---**drop list**---- and or /such associates and assistants as may be designated by her to perform the above said procedure.

I am aware of the reasons for the above said procedure.

I am aware of the alternative methods like treatment with antibiotics and waiting

I am also aware of the outcome of the said procedure in terms of risks
(Spread of infection, rarely septicemia 1%, necrotizing fasciitis very rarely, bleeding, delayed wound healing and recurrence 6 – 27%).

Additional remarks**text box**.....

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

I give my consent to perform the procedure

Name and signature of Patient: **Auto entry for name**

Name and Signature of the Doctor: **drop list of our list of doctors**

Name, Relationship and Signature of the witness:

Consent for The Procedure – Hymenectomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I authorize Dr. -----(drop list)----and or /such associates and assistants as may be designated by her to perform the above said procedure.

I am aware of the reasons for the above said procedure.

I am also aware of the outcome of the said procedure in terms of risks
(Bleeding after hymenectomy, Infection, Inflammation, Less than expected results that is, persistent pain during sex or when you insert a tampon, Scarring that requires a second procedure to remove, Injury to other organs - such as urethra, Lingered pain).

Additional remarkstext box.....

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent Form For Hysteroscopy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

A hysteroscopy is a surgical procedure that allows visualization of the uterine cavity. This procedure allows the diagnosis and treatment of abnormalities in the uterine cavity.

PROCEDURE

Before the procedure it is important that you do not eat or drink anything for 6-8 hours. You should follow the advice given by your doctor about the medication.

When you arrive at the surgical suite, an anesthesiologist will start an intravenous line. You will then be taken to the operating room and the anesthesia will be administered.

A small telescope-like instrument, called a hysteroscope, is inserted into the uterine cavity. Distension of the cavity with a solution then allows examination of the uterine cavity.

If any abnormalities are identified, such as a polyp, fibroid, uterine septum, or intrauterine adhesions, special instruments can be introduced and an attempt can be made to treat the condition.

In some cases, following the hysteroscopy, a uterine curettage is performed with a small instrument, called a curette, which allows sampling of endometrial tissue.

POST-OPERATIVE CARE

After the procedure has been completed, you will spend a few hours in the recovery room and then be discharged home. Since you may be drowsy following the procedure, it is important that someone is available to transport you home and be with you.

It is not uncommon to have some vaginal bleeding and mild lower abdominal cramping following the procedure. You should plan on resting the following day after the surgery.

There are no restrictions on showering or bathing. You should refrain from intercourse and douching for one week following the procedure.

If during the post-operative course, you develop any fever, chills, severe abdominal pain, heavy vaginal bleeding, or any other abnormal symptoms, call your physician immediately. If you should have any difficulty in contacting your physician you should proceed to the emergency department of the nearest hospital.

COMPLICATIONS:

Serious complications following a hysteroscopy are rare.

One complication from this procedure is perforation of the wall of the uterus. If this occurs, the procedure is stopped and a decision may be made to examine the injury site by a laparoscopy. In most instances, the bleeding at the perforation site is minimal, and the perforation heals without problems. Perforation can result in injury to adjacent organs

including the intestines, bladder, ureters, uterus and blood vessels. Injury to these organs could result in extended stay in the hospital and additional surgery to repair the injury. Another complication following a hysteroscopy is fluid overload. Fluids are used to distend the uterine cavity to allow the procedure to be performed. Some fluid is absorbed into the blood vessels. The amount of fluid absorbed is followed carefully to avoid fluid overload. Fluid overload can compromise the function of the heart and lungs. In rare cases fluid overload can cause brain injury. Death is a very rare complication following a hysteroscopy.

ACKNOWLEDGEMENT OF INFORMED CONSENT

I acknowledge that I have read and understand this written material.

I understand the purpose, risks and benefits of this procedure.

I am aware that there may be other risks and complications not discussed that may occur.

I also understand that during the course of the procedure, unforeseen conditions may be revealed requiring the performance of additional procedures.

I also understand that technical problems with the instrumentation may prevent the completion of the procedure.

I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required as a result of this procedure.

This procedure has been explained to me in language that I understand. I have been given the opportunity to ask questions which have been answered to my satisfaction. I have also considered other options and alternatives.

Additional remarkstext box.....

I consent to the performance of the procedure described above.

I have been found to have _____

And proposed to go through _____

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Laparoscopic Surgery

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

Laparoscopy involves the insertion of a laparoscope through a small incision on the abdominal wall to view the peritoneal cavity and pelvic organs specifically in order to identify a cause for the patient's symptoms. This involves the use of additional small incisions to allow the use of instruments to move structure within the abdomen to allow a thorough inspection and possible treatment if agreed in advance

I have been explained the need for laparoscopic surgery for the following indication /s

The other medical and less invasive procedures and alternative therapies including the option of 'No treatment', has been discussed with me and I have opted for this modality of treatment.

I understand that the procedure will be done under suitable anesthesia.

Women who are obese or very thin; who have significant pathology; who have had previous surgery; or who have preexisting medical conditions must understand that the quoted risks for serious or frequent complications will be increased. The risk of serious complications at laparoscopy also increases if an additional therapeutic procedure is performed. Women should also be advised that laparoscopy may not identify an obvious cause for her presenting complain

I understand the following are the:

Commonly occurring risks at the time of surgery/immediately post-operative period.

- The surgery carries a risk of infection of wound /urinary system(10%) which is minimized by routine use of antibiotics.
- Excessive bleeding may necessitate blood transfusion (1.5-3%).
- Persistent wound /abdominal discomfort /frequency of micturition for a few months
- Bloating feeling and shoulder pain for few days
- Delayed wound healing, keloid (thick scar) formation

Uncommon/ serious risks

- Accidental Injury to the urinary bladder /ureter (1%) intestine (2%)—in such event extra procedure will be required to repair the same, by appropriate specialist. However, up to 15% of bowel injuries might not be diagnosed at the time of laparoscopy
- Damage to blood vessels and nerves (<1%)
- Return to the theatre for additional stitches (0.6%)
- Infection, pelvic abscess (< 0.2 %)

- Risk of blood clots (<1 %) in the veins of the legs which is reduced by appropriate measures
- Conversion to open surgery (1-25%)
- Failure to gain entry to the abdominal cavity and to complete the intended procedure.
- Hernia at site of entry (less than 1 in 100; uncommon).
- 3–8 in 100 000 women (very rare) undergoing laparoscopy may die as a result of complications

Additional remarkstext box.....

Wishes of the patient –

I also authorize the doctor to carry out any extra procedure/s that may become necessary during the surgery.

Consent to the performance of the procedure described above.

I have been found to have _____

And proposed to go through _____

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent For Laparotomy

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent:

Date of scheduled procedure:

Condition and treatment

The doctor has explained that I have the following condition

.....
This condition requires the following procedure
.
.....

The following will be performed:

Surgical examination of the inside of the abdomen and the internal organs for any abnormality. This is done through a 15-30cm cut into the abdomen, depending on the size of the abdomen.

Risks of this procedure: There are risks and complications with this procedure. They include but are not limited to the following:

General risks:

- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs
- Small areas of the lung can collapse, increasing the risk of chest infection. This may need antibiotics and physiotherapy.
- Increased risk in obese people of wound infection, chest infection, heart and lung complications, and thrombosis.
 - Blood clot in the leg (DVT) causing pain and swelling. In rare cases part of the clot may break off and go to the lungs.
- Death as a result of this procedure is possible.

Specific risks:

- Deep bleeding in the abdomen. This may need fluid replacement, blood transfusion or further surgery. This may mean a longer stay in hospital and longer recovery time.
- Damage to other organs, such as bladder or bowel, which may need further surgery. This may mean a longer stay in hospital and longer recovery time.
- Infections such as pus in the abdomen. This may need surgical drainage and antibiotics.
- Bowel blockage after the operation. This may be temporary or in the longer term. Treatment may be a drip to give fluids into the vein and no food or fluids by mouth. If it doesn't get better, bowel surgery may be necessary which may include a colostomy. This can be temporary or permanent.
- Adhesions (bands of scar tissue) which can cause bowel obstruction. This can be a short term or long-term complication and may need further surgery
- The wound may not heal normally. The scar can be thickened and red and may be painful. This is permanent and can be disfiguring.
- Poor wound healing. The wound may burst open which may require long term wound care with dressings and antibiotics, or a hernia. This may need repair by further surgery.
- Increased risk in smokers of wound and chest infections, heart and lung complications and thrombosis.
- Very low possibility of a fistula (a connecting passage between one area and another) developing.

Significant risks and procedure options

Risks of not having this procedure

Additional remarkstext box.....

Patient consent

I acknowledge that the doctor has explained;

- My medical condition and the proposed procedure, including additional treatment if the doctor finds something unexpected. I understand the risks, including the risks that are specific to me.
- Other relevant procedure/treatment options and their associated risks.
- My prognosis and the risks of not having the procedure.
- That no guarantee has been made that the procedure will improve my condition even though it has been carried out with due professional care.
- The procedure may include a blood transfusion.
- Tissues and blood may be removed and could be used for diagnosis or management of my condition.
- If immediate life-threatening events happen during the procedure, they will be treated

I request to have the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for the OPD procedures

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I authorize Dr. drop list and or /such associates and

Assistants as may be designated by her to perform the procedure drop list

I am also given to understand that apart from the above-mentioned procedures the following are the possible alternative treatment –

I am aware of the reasons for the selected modality text box

I am also aware of the outcome of the said procedure in terms of risks, success rate as well as failure to achieve intended result text box

I am aware of the small risk of infection (which will be greatly prevented with suitable medication) and pain and possible inability to perform the procedure in the outpatient setting.

All above points have been explained to me in the language that I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness: _____

This form can be used for small OPD procedures like

1. Pipelle biopsy

9. ultrasound guided procedures

- | | |
|--------------------------------------------|----------------------------|
| 2. Cervical biopsy | 10. Coring |
| 3. Cryo-cautery / cervical electrocautery. | 11. Endocervical curettage |
| 4. Cervical polypectomy. | 12. IUCD removal. |
| 5. Colposcopy + guided procedure. | 13. Mock transfer. |
| 6. LEEP/LETZ | |
| 7. Vulvar biopsy | |
| 8. Vaginal biopsy | |

Consent for IUCD Insertion

DocumentUltimate

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

I authorize Dr. _____ (drop list – of clinic doctors) _____ and or /such associates and assistants as may be designated by her to perform the procedure, insertion of intrauterine device
two options Cu –T (text box to be activated if Cu-T selected)/ LNG – IUS called MIRENA

I am also given to understand that apart from the above-mentioned procedures the following are the possible alternative treatment –natural methods /oral pill/barrier/Depot Provera for contraception, their benefits and side effects

I am aware of the reasons for the selected modality - two options – Cu –T and Mirena

I am also aware of the outcome of the said procedure in terms of risks , success rate as well as failure to achieve intended result contraception

I am aware of the small risk of infection (which will be greatly prevented with suitable medication) and pain and possible inability to perform the procedure in the outpatient setting.

Additional remarkstext box.....

All above points have been explained to me in the language I understand.

I have been given ample opportunity to clarify doubts on the procedure /treatment protocol.

I give my consent to perform the procedure

Name and signature of Patient:

Name and Signature of the Doctor:

Name and Signature of the witness:

DocumentUltimate

Consent for Termination Of Pregnancy (TOP)

There are 2 methods -Medical (MTOP)/ surgical (STOP)

MTOP- <7weeks of pregnancy

MTOP is widely used and relatively safe.

However, every form of medical treatment has some potential risk or side effect although small, like, Excessive bleeding, Infection, incomplete abortion.

Failure of method – in which case you cannot continue pregnancy, you need to terminate surgically as there is risk of congenital deformity in the baby in case of continuation of pregnancy.

Option is given to all women seeking termination of pregnancy up to 7 weeks period of gestation (49 days) provided you accept

- A minimum of three follow-up visits.
- You need to avoid going out of station
- **In case of heavy bleeding any time, you have to report as an emergency to labor room in the hospital as instructed to you.**
- **You may have to undergo surgical abortion (STOP/D&E) to control bleeding.**

MTOP may not be suitable if you have any of the following: -

- Anemia with Hb %<8g,
- High blood pressure /High cholesterol / cardiovascular diseases
- On long term corticoid-steroid treatment /Anti coagulation therapy/
- Long term smoker.
- Severe renal, liver or respiratory diseases • Glaucoma • Uncontrolled seizure disorder.
(If you have any of these conditions, please inform the doctor)
- Suspected /confirmed ectopic pregnancy / undiagnosed adnexal mass-on scan.
- If you cannot reach hospital in emergency
- If you are an anxious woman wanting quick abortion.
- Language or comprehension barrier
- Women unable to take responsibility &
- **If you are not willing for surgical abortion in case of failure**

Signature of patient

signature of Doctor

Page 1/4

Protocol (MTOPI)

You will be given 2 types of medication 48hours apart

1st visit after history and examination you need to do blood test to check for anemia, and to see your blood group / Rh.

If you have Rh negative blood you need to take injection Anti D to prevent problems in the next pregnancy

Preferable to do scan to confirm that pregnancy is in uterus.

2nd visit –if you are suitable candidate one set of tablet under supervision is given after taking consent A small percentage (3 %) may expel products with this 1st drug alone, but total drug dosage scheduled with (2nd dose) must be completed.

If you vomit the tablet within two hours of taking it you will need to return to the clinic/hospital to take another tablet.

You are advised not to drink alcohol or smoke.

3rd visit –For 2nd dose of medication you will be asked to come for taking medication (oral /vaginal) in 48 hours. After this, you may have bleeding in excess of menstrual flow, you may have severe menstrual cramp like pain within 6hours. Vaginal bleeding usually occurs for 10-14 days. Please use only sanitary pads and NOT tampons

If you need pain relief use the one that is recommend by the doctor. The usual painkiller can halt the process of abortion.

Nausea (12-47%) vomiting (9-45%) and diarrhea (7-67%) can occur but are generally mild and self-limiting

4th visit (~on day 15): to ensure that abortion is complete by pelvic ultrasound (scan) You should not miss this appointment, If abortion is complete as noted by this scan, till the next menses, you have to avoid intercourse.

The success of abortion with drugs depends on multiple factors.

Alternate method- Surgical TOP (D & E) needs a day's admission to hospital.

You need to bring one responsible adult to be with you (friend /relative /partner/husband)

Method -Vacuum Aspiration (Suction evacuation) is the most commonly-used method for termination of early pregnancies. However, being a surgical technique, it is associated with risks of infection, perforation of uterus, incomplete abortion and Asherman's Syndrome. (Scarring in uterus). However antibiotics are used to avoid infection. USG guidance can avoid complications (like perforation / incomplete abortion).

You need to be on empty stomach for 6hours prior to the procedure (to make anesthesia safe)

After admission one tablet may be kept in vagina 4 hours prior to the procedure to facilitate the surgery.

After 6hours of the procedure you will be fit to go home

Signature of patient

signature of Doctor

Page 2/4

DocumentUltimate

Surgical abortion is preferred if

- Patient desires concurrent tubal ligation.
- If the pregnancy is >7weeks.
- Woman is anxious wanting quick abortion.

You have full option of choosing suction evacuation for terminating her pregnancy if you do not want to use medical abortion.

- During treatment and, preferably, till the next menses, you will have to avoid intercourse.
- Next menses may be delayed by one to two weeks, but subsequent menses will revert to original cyclicity.

You have to sign a consent form after being satisfied with all the information Provided.

Scan report

Hb%

Blood group Rh:

Follow-up scan date:

Contact number:

I have read and understood the above information and I consent to follow the advice.

Signature of patient

signature of Doctor

Page 3/4

FORM C - Form of consent
(See rule 9)

DocumentUltimate

I -----daughter/wife of ----- aged
about ____ years, residing at

Hereby give my consent to the Medical termination of my pregnancy at

Signature of patient

Signature of witness

Signature of doctor

Place:

Date:

(To be filled in by guardian where the woman is a mentally ill person or minor.)

I ----- son / daughter / wife of -----

aged about _____ years residing at _____

hereby give my consent to the termination of the pregnancy of my ward _____

who is a minor/mentally unstable ,at _____?

Guardian's Name and Signature

Signature of witness

Signature of doctor

Date

Page 4/4

CONSENT TO OFFICE HYSTEROSCOPY

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date of obtaining consent: _____

Date of scheduled procedure: _____

- 1) By signing this form, I give my consent to the procedure listed above to be done by my doctor.
- 2) My doctor may have other doctors assist or do part of the procedure or if necessary, my doctor may have another doctor take his/her place during the procedure.
- 3) The doctors may find something they did not expect. If this happens, the doctors may use their judgment and change the procedure.
- 4) I know medical science is not perfect and many things are not predictable. No one has given me a promise or a guarantee of what the results of the procedure will be. I have also been informed that in the performance of any surgical or invasive medical procedure there are risks such as, but not limited to severe blood loss, infection, and cardiac arrest.
- 5) I know that it is my responsibility to tell the doctors about allergies I have, any drugs or medications I have taken, when I have eaten or taken alcohol, any drugs or medications I should not have, and any other health problems I have. I understand it is important to my health and safety to follow the doctors' instructions before and after the procedure.
- 6) I know I could experience blood loss or other complications. If this happens, I may need to be transported to a hospital for observation and may need blood or products made from

blood. I wish to receive blood and/or blood products if the doctors' feel it is necessary.

_____ (initial)

7) I know that specimens and tissue may be taken from my body during the procedure. I consent to having this done if the doctor feels it is necessary.

8) My doctor has answered all of my questions to my satisfaction.

9) Specific complications associated with Office Hysteroscopy include but are not limited to: bleeding, infection, reaction to the anesthetic agent, perforation of the uterus with injury to bowel, bladder, or other internal organs.

I have read (or have had read to me) the above matter and I know what it means.

Name and signature of Patient: **Auto entry for name**

Name and Signature of the Doctor: **drop list of our list of doctors**

Name, Relationship and Signature of the witness:

DocumentUltimate

Consent Form for HIV Testing

Patient Name: _____ Age: _____

W/o or D/o: _____ IC No. _____

Doctor: _____ Date: _____

Introduction: HIV is Human Immunodeficiency virus. A person infected with this virus can spread to others through unprotected sex, needle sharing & donating blood /other tissues. Infected mother can spread HIV to new born.

HIV testing is recommended to be done for all pregnant women. It is also recommended prior to some procedures like IUI/ any surgery.

A Positive test for HIV-means this test detects antibodies which are body's reaction to the HIV, not the virus itself. The blood test usually turns positive within 1 month after infection and in almost all cases within 3months. (Window period).

If a person is infected with HIV, it does not mean he has Acquired Immune Deficiency Syndrome (AIDS) which is an advanced form of HIV infection.

A Negative test means that HIV antibodies were not detected. This usually means that the person is not infected with HIV. In some cases, however, the infection may have happened too recently for the test to be positive. (Window period).

Benefits of being tested: Most infected persons may benefit from medications: reduction in the risk of transmission from mother to unborn child, delayed development or prevention of AIDS (Acquired Immune Deficiency Syndrome) and other serious infections. Test results also can help people make choices about contraception or pregnancy. Therefore, all infected persons should have a complete medical check-up, including tests of the immune system, to help their health care providers recommend the best health care.

Privacy and confidentiality: your results will not be disclosed to anybody unless you direct us to do so or unless the law authorizes or compels us to do so.

Consent for HIV (Human Immunodeficiency virus) testing:

I have read and understood the above information. It has been explained to me in a language that I understand. I understand that I have the alternative of not being tested.

I hereby authorize to perform this test.

Signature of the patient

Signature of the counsellor

Date:

DocumentUltimate

Consent Form To Be Signed By The Couple
(For Infertility Treatment)

(Guidelines for ART Clinics in India ICMR/NAMS 81 4.1)

We have requested the Centre (named above) to provide us with treatment services to help us bear a child. We understand and accept (as applicable) that:

1. The drugs that are used to stimulate the ovaries to raise oocytes have temporary side effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs, where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent, in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

2. There is no guarantee that: a. The oocytes will be retrieved in all cases. b. The oocytes will be fertilized. c. Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred. All these unforeseen situations will result in the cancellation of any treatment.
3. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are replaced.
4. Medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.
5. Endorsement by the ART clinic I/we have personally explained to ___(husband)_ and ___(wife)___ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications
6. This consent would hold good for all the cycles performed at the clinic.

Name and Signature of the Husband:

Name and Signature of the Wife:

Name, Address and Signature of the Witness from the clinic:

Name and Signature of the Doctor:

Dated:

Consent for Artificial Insemination with Husband's Semen

(Guidelines for ART Clinics in India ICMR/NAMS 81 4.2)

We, ___(Name of husband – from Registration details – auto entry)___ and ___(Name of patient – from registration details – auto entry)___, being husband and wife and both of legal age, authorize Dr. . ___(drop list – our clinic doctors)___ to inseminate the wife artificially with the semen of the husband for achieving conception.

We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result. We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

The procedure(s) carried out does (do) not ensure a positive result, nor do they guarantee a mentally and physically normal body.

This consent holds good for all the cycles performed at the clinic.

Endorsement by the ART clinic

I/we have personally explained to ____(husband)___ and ____(wife)___ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Name, Address and Signature of the Witness from the clinic:

Name and signature of Patient: Auto entry for name

Name and Signature of the Doctor: drop list of our list of doctors

Name, Relationship and Signature of the witness:

Consent for Artificial Insemination with Donor Semen

(Guidelines for ART Clinics in India ICMR/NAMS 82 4.3)

We, ____(Name of husband – from Registration details – auto entry)___ and ____(Name of patient – from registration details – auto entry)___, being husband and wife and both of legal age, authorize Dr. ____(drop list – our clinic doctors)___ to inseminate the wife artificially with semen of a donor (registration no. ____(text box)___; obtained from ____(text box)___ semen bank for achieving conception.

We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result.

We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

We declare that we shall not attempt to find out the identity of the donor. I, the husband, also declare that should my wife bear any child or children as a result of such insemination (s), such child or children shall be as my own and shall be my legal heir (s).

The procedure(s) carried out does (do) not ensure a positive result, nor do they guarantee a mentally and physically normal body. This consent holds good for all the cycles performed at the clinic.

Endorsement by the ART clinic

I/we have personally explained to __ (husband) __ and __ (wife) __ the details and implications of his/her/their signing this consent/approval form, and made sure to the extent humanly possible that he/she/they understand these details and implications.

Name, Address and Signature of the Witness from the clinic Signed:

Name and Signature of the Husband:

Name and Signature of the Wife:

Name, Address and Signature of the Witness from the clinic:

Name and Signature of the Doctor:

DocumentUltimate