

**INFORMED CONSENT AND REQUEST FOR DILATATION AND CURETTAGE  
(D & C, which may include Hysteroscopy, Operative Hysteroscopy and/or Cervical Biopsy)**

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

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

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

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

2. The nature of the procedure is to enlarge the opening to the patient's uterus and to scrape the lining of the uterus to obtain tissue or suction to obtain tissue, which may include removal of tissue from the tip of the uterus and/or use of a small telescope type instrument to remove tissues. Operative Hysteroscopy may involve using electrical surgical equipment to remove tissue and/or destroy the uterine lining in order to lessen or stop menstruation. The planned procedure is: \_\_\_\_\_.

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

**4. MATERIAL RISKS OF THE PROCEDURE**

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

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

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

- a. perforation of the uterus (one of the instruments might go through the wall of the uterus) which might require immediate surgery or other additional surgery that might include the removal of the uterus, fallopian tubes and/or ovaries;
- b. inability to get pregnant or carry a pregnancy to term;
- c. injury to the cervix, uterus, fallopian tubes and/or bowel;
- d. blood loss necessitating transfusion which carries the risk of exposure to AIDS, hepatitis, and other infectious diseases;
- e. formation of blood clots;
- f. emboli (clots of blood and other material) that may travel to other parts of the body;
- g. fistula formation (an opening between bowel, bladder, ureter, vagina and/or skin) caused by an injury to the bowel, bladder, or ureter;
- h. need for immediate surgery or other additional surgery, which might include a hysterectomy (removal of the uterus, fallopian tubes and/or ovaries);
- i. incomplete removal of tissue requiring a repeat procedure (for D and C with miscarriage).

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

7. The practical alternatives to this procedure are to do nothing and accept the consequences of the current condition, or hormone and/or drug therapy, or biopsy of the lining of the uterus (endometrial biopsy) or cervix (cervical biopsy), or sonohysterography.

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

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

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

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

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

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

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

\_\_\_\_\_  
Witness

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

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

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

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

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