DISCLOSURE AND CONSENT FOR HYSTERECTOMY

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

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

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

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

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

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

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

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

1. Fever
2. Transfusion reaction, which may include kidney failure or anemia
3. Heart failure
4. Hepatitis
5. AIDS (acquired immune deficiency syndrome)
6. Other infections

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

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

☐ **ABDOMINAL HYSTERECTOMY**	☐ **VAGINAL HYSTERECTOMY ***
1. Uncontrollable leakage of urine 2. Injury to the bladder. 3. Sterility. 4. Injury to the tube (ureter) between the kidney and the bladder. 5. Injury to the bowel and/or intestinal obstruction.	1. Uncontrollable leakage of urine. 2. Injury to the bladder. 3. Sterility. 4. Injury to the tube (ureter) between the kidney and the bladder. 5. Injury to the bowel and/or intestinal obstruction. 6. Completion of operation by abdominal incision.

* For **LAPROSCOPICALLY ASSISTED VAGINAL HYSTERECTOMY**, the additional risks include: damage to intra-abdominal structures (e.g. bowel, bladder, blood vessels, or nerves); intra-abdominal abscess and infectious complications; trocar site complications (e.g., hematoma/bleeding, leakage of fluid, or hernia formation); conversion of the procedure to an open procedure; cardiac dysfunction.

ADDITIONAL COMMENTS: _____

_____

_____

I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (we) understand that certain complications may result from the use of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or even death. Other risks and hazards, which may result from the use of general anesthetics, range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

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

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

NAME OF PHYSICIAN EXPLAINING PROCEDURE: _____

NAME OF PERSON PROVIDING MATERIALS: _____

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required)

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

WITNESS:

_____

Signature

_____

Name (Print)

_____

Address (Street or P. O. Box)

_____

City, State, Zip Code