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 to consent to receive this care/procedure. Please ask your physician/health care provider any remaining questions you have before signing this form.

HM2696

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.

NOTICE: You have the right to seek consultation from a second physician before deciding whether or not to consent.

I voluntarily request 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 as:

_____

_____

_____.

I understand that the following surgical, medical, and/or diagnostic procedures are planned for me:

_____

_____

_____.

I understand that a hysterectomy is a removal of the uterus through an incision in the lower abdomen (abdominal hysterectomy) or vagina (vaginal hysterectomy). I understand that the hysterectomy is permanent and not reversible. I understand that I will not be able to become pregnant or bear children.

I understand that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina.

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I 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 **DO / DO NOT** consent to the use of blood and blood products as deemed necessary. I understand that the following risks and hazards may occur in connection with the use of blood and blood products:

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

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 understand that all surgical, medical, and or/diagnostic procedure(s) involve some risks, ranging from minor to severe. These risks include infection, blood clots in veins, lungs or other organs, hemorrhage (severe bleeding), allergic reactions, poor wound healing, and death. The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient's current health.

I also realize that the following risks and hazards may occur in connection with this particular procedure (check applicable procedure):

_____ Abdominal or Vaginal Hysterectomy

1. Uncontrollable leakage of urine.
2. Injury to the bladder.
3. Injury to the tube (ureter) between the kidney and the bladder.
4. Injury to the bowel and/or intestinal obstruction.
5. Need to convert to abdominal incision.

ADHERE PATIENT LABEL WITHIN THIS AREA

_____ LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, additional risks include:

1. Damage during introduction of trocar to adjacent intra-abdominal structures and organs (e.g., bowel, bladder, blood vessels, or nerves) and potential need for additional surgery.
2. Trocar site complications (e.g., hematoma, bleeding, leakage of fluid, or hernia formation).
3. Air embolus (bubble causing heart failure or stroke).
4. Change during the procedure to an open procedure.
5. If cancer is present, may increase the risk of the spread of cancer.

I understand that in addition to my physician or health care provider, residents, medical students, advanced practice provider students (such as nurse practitioners or physician assistants), and other applicable students, may be performing important, medically necessary tasks related to my surgery, or examinations or invasive procedures for educational and training purposes, in accordance with the hospital's policies and under the supervision of my physician or health care provider. Important surgical tasks include, but not limited to: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices, and placing invasive lines.

Y / N _____ (Pt. Initials) I consent to students, including, but not limited to, residents, medical students, advanced practice provider students (such as nurse practitioners or physician assistants), and other applicable students, conducting examinations outside the medically necessary procedure for educational and training purposes. These examinations include, but are not limited to, breast, pelvic, prostate, and rectal examinations.

ADDITIONAL COMMENTS:

_____

_____

_____

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

I 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 understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

In signing below, I consent to the care/procedure(s) described above. I acknowledge the following (please initial):

_____ I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
_____ I have been given an opportunity to ask questions that I may have about:
1. Alternative forms of treatment;
2. Risks of non-treatment;
3. Steps that will occur during my care/procedure(s); and
4. Risks and hazards involved in the care/procedure(s).

_____ I believe I have enough information to give this informed consent.
_____ I certify this form has been fully explained to me and the blank spaces have been filled in.
_____ I have read this form or had it read to me.
_____ I understand the information on this form.

If any of these statements are not true for you, please talk to your physician/health care provider before continuing.

NAME OF PHYSICIAN EXPLAINING PROCEDURE: _____

NAME OF PERSON PROVIDING MATERIALS: _____

Print Name: _____ Signature _____

If Legally Authorized Representative, list relationship to Patient: _____

Date: _____ Time: _____ AM/PM (circle one)

Witness:

Print Name: _____ Signature _____ Date _____ Time _____

Name and/or ID number of the qualified interpreter (if applicable): _____

Signature of qualified interpreter (if applicable): _____

Date _____ Time _____

ADHERE PATIENT LABEL WITHIN THIS AREA