CONSENT TO SURGERY

Patient Name: _____

Date of Procedure: _____

Physician: _____

The procedure planned is: Office Hysteroscopy

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. I also give my consent to the nurse and technical people at Van Dyke Gynecology to deliver care according to the Van Dyke Gynecology standards of care.
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 it is up to me 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. I understand that if I think of more questions, I should ask them before the procedure and my doctor will answer them.
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.

Consent to Surgery – Office Hysteroscopy (cont.)

I have read (or have had read to me) the above "Consent to Surgery." I know what it means. I have requested and consent to having the procedure listed above performed within thirty (30) days from the date identified below.

_____	_____
Signature of Witness	Signature of Patient
_____	_____
Date/Time	Date/Time