Jeri Shuster, M.D., P.A.
and Women's Center, Inc.

Jeri Shuster, M.D., Fellow of the American College Obstetricians and Gynecologists
Kathryn Cervi, C.R.N.P., Women's Health Care Nurse Practitioner

INFORMED CONSENT: COLPOSCOPY

I hereby request and authorize Dr. Jeri Shuster to perform upon me the following procedure(s)

Cervical biopsy and/or Endocervical biopsy

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment.

I have been given ample time to make my decision to undergo this procedure. I have been given the opportunity to consult with other physicians concerning my condition and the treatment if I so desire.

I understand that the risks of office GYN surgical procedures include infection and bleeding. Additional risks include failure to diagnose the cause of the underlying condition or failure to cure the condition. Following the procedure, adverse effects may include feeling lightheaded, weak, nauseous or crampy.

For COLPOSCOPY, major risks are uncommon. These include: bleeding, infection and lightheadedness. Alternatives include: Pap, Papnet, Thin prep Pap, HPV-DNA, not doing colposcopy or doing colposcopy without biopsy.

I am aware that circumstances could arise during the course of treatment which could necessitate the performance of operations and procedures which are different from, or in addition to, those now contemplated. I am aware that the practice of medicine & surgery are not exact sciences and that there are risks and complications associated with this procedure. The possibility of severe blood loss, infection, injury, and rarely, cardiac arrest are associated with this procedure. I authorize my physician with her assistants to perform additional procedures which, in their judgment, are incidentally necessary to carry out my treatment.

I authorize the administration of local anesthesia.

I authorize the emergency administration of blood or blood products.

If applicable, I consent to the taking of intra-operative photographs during the course of this procedure.

I authorize the examination by an authorized individual of any tissue or sample removed from my body as a result of the procedure(s) as well as disposal of same.

I understand that I have the right to refuse any medical or surgical procedures or treatment.

I certify that I have read and fully understand the above consent and have no further questions which I need answered prior to the procedure and that all the blanks on this form have been filled in.

DATE: _____________________ SIGNATURE: ____________________________________

WITNESS: ____________________________________

JERI SHUSTER, M.D:______________________________

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