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: HYSTEROSCOPY (Page 1 of 2)

I hereby request and authorize Dr. Jeri Shuster to perform upon me the procedure(s): **hysteroscopy**. I understand that this procedure involves placing a telescope-like device (hysteroscope) through the canal of the cervix and into the uterus. The uterus will be distended by filling it with sterile liquid.

I consent to the performance of **all other related procedures in bold on this consent form**, to be determined by the findings at the time of hysteroscopy. I request and authorize treatment for findings during hysteroscopy that may be related to my symptoms, including abnormal menstrual bleeding, pelvic pain, or abnormal findings on ultrasound.

The findings at hysteroscopy will determine what procedure, if any, will follow the hysteroscopy. If any anatomic or physical abnormality is detected, it will be removed or sampled by any of a variety of techniques including **endometrial biopsy** or **suction dilation and curettage** (using a soft device, similar to a drinking straw into the uterus to obtain a sample of the glands and tissue lining the uterus), **sharp curettage** (spoon-like device to scrape out a sample of the uterine lining), **endometrial or endocervical polypectomy** (removal of polyps from uterus or cervix using grasping device or electrical excision), **cystectomy** (removal of cysts utilizing the above techniques), or **myomectomy** (removal of fibroids by grasping, or electrical excision). If polyps or fibroids are present, their removal will require adequate **dilation of the cervix**. Dilation and **electrical techniques** are usually best carried out using intravenous sedation. For patients preferring to have the procedure awake with local anesthetic (those who prefer to avoid IV sedation due to personal preference, medical illness, or ultrasound indicating low likelihood of polyps or fibroids), if an anatomic condition is discovered, a subsequent procedure under sedation may be scheduled at a later date.

Risks include: bleeding, infection, burn injury, pain, scar tissue formation (adhesions), failure to diagnose or cure the underlying condition, inability to visualize any or all of the cervical canal or uterine cavity, perforation of the uterus with injury to internal structures (uterus, cervix, tubes, ovaries, bowel, bladder, ureter, blood vessels, nerves), persistence or recurrence of the condition.

Benefits include: potential to identify the cause of the symptoms as well as alleviating or ameliorating them. The procedure usually enables us to determine hormonal, anatomic, precancerous, or malignant etiology of symptoms.

Alternatives include: not doing the procedure, limiting the extent of the procedure (e.g. endometrial biopsy without hysteroscopy), trial of medical or hormonal treatment, hysterosonogram, and performing the procedure(s) in a hospital.

_____ Patient Initials (Page 1 of 2)

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(continued) **INFORMED CONSENT: HYSTEROSCOPY** (page 2 of 2)

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 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 and 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 cardiac arrest could be associated with this procedure. I authorize my physician or her assistants to perform additional procedures which, in their judgment, are incidentally necessary to carry out my treatment.

I authorize the emergency administration of blood or blood products. I consent to the taking of intra-operative photographs.

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.

Patient / Guardian Signature	Date
Witness Signature	Date
Jeri Shuster MD / Kathryn Cervi CRNP	Date

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