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: DILATION AND CURETTAGE (D & C)

I hereby request and authorize Dr. Jeri Shuster to perform upon me the following procedure: Dilation and Curettage (D & C).

I have been advised of the nature and purpose of the proposed surgical procedure, 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 this procedure include: bleeding, hemorrhage, infection, failure to diagnose the cause of the underlying condition, and failure to cure the condition. Following the procedure, adverse effects may include feeling lightheaded, weak, nauseous or crampy.

I understand that alternatives include: endometrial biopsy, hysteroscopy, or no procedure.
In some instances, sonogram, fibroid removal, hysterectomy, or destruction of uterine lining could be alternatives.

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 and surgery are not exact sciences and that there are risks and complications 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 emergency administration of blood or blood products.

I consent to the taking of intra-operative photographs during this procedure.

I authorize the examination by an authorized individual of any tissue or sample removed from my body as a result of this procedure or treatment.

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

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ THE FORM AND UNDERSTAND THE FORM.

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

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