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INFORMED CONSENT AND REQUEST FOR ENDOMETRIAL ABLATION

I,______________________________ request Dr PJ Geyser and his associates / assistants to perform upon me:
Endometrial ablation or resection

Diagnosis and Procedure: The following has been explained to me in general terms and I understand that:

- My condition has been diagnosed as:______________________________
- The nature of this procedure is: Diagnosis and surgical procedure according to diagnosis.

General Risks of surgery: As a result of the performance of this procedure there may be general risks of : *INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.* In addition to these general risks, there may be other possible risks involved in this procedure. These risks and/or complications may include but are not limited to such complications as:
Injury to bowel, bladder, ureter (tube from kidney to bladder) and urethra (tube from bladder to outside of body)

1. Formation of a vesico-uterine fistula
2. Injury to the abdominal cavity, cervix, vagina and fallopian tubes
3. Colostomy
4. Perforation of the uterine wall and thermal injury to adjacent tissue
5. Blood loss which may lead to blood transfusion
6. Infection or sepsis
7. No or slight improvement of my current condition
8. The procedure does not render me sterile and contraception is needed. If I do become pregnant, it is dangerous to me and the fetus and Hysterectomy will have to be done
9. Air or gas embolism

Alternative forms of treatment include:

1. Do nothing and accept my present condition
2. Hormone therapy intra-uterine apparatus
3. Medication and hormone therapy

These alternative treatments have been explained to me, and I have elected this surgical procedure as my method of treatment.

Informed Consent: I understand and accept that during the procedure unexpected and unforeseen circumstances may make it necessary to do an extension of the original procedure or another procedure that is not named above. I request Dr PJ Geyser and his associates / assistants to perform those additional procedures that they judge to be necessary.
BY SIGNING THIS FORM, I AKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND EXPLAINED TO ME AND THAT I FULLY UNDERSTAND ITS CONTENTS.

I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. All blanks or statements requiring completion were filled in and all statements with which I disagree were marked out before I signed this form.
I accept that medicine is not an exact science and understand that no guarantees can be given as to the results.
Understanding these limitations, I request Dr PJ Geyser and his associated / assistants to proceed with surgery.

Patient: ______________________________ Date: ______________________________

Patient unable to sign bacause of: ______________________ Relationship to patient: ______________________

Person giving consent: ______________________ Witness: ______________________