



# Dr. PJ (Pieta) Geysler

MB ChB (Stell) MMed (OetG) (Pret) FCOG (SA)

**Ginekoloog & Verloskundige • Gynaecologist & Obstetrician**

Kerkstraat 148  
Rustenburg, 0299  
Postnet Suite 83  
Privaatsak X82329  
RUSTENBURG, 0300

Pr. 1609815

Tel. (014) 594 0340  
(014) 594 0341  
Faks (014) 594 0342  
Tel. (014) 592 7059 (H)  
Sel. 083 457 4980

## INFORMED CONSENT AND REQUEST FOR STERILIZATION

I, \_\_\_\_\_, request Dr PJ Geysler and his associates / assistants to perform upon me (circle):

1. Removal of a portion of the tubes through an incision in my lower abdomen.
2. Laparoscopy. ("band-aid" incision or incisions)
3. Essure Sterilization

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

This procedure is NOT designed to be reversible, and that I am intentionally giving up my ability to become pregnant.

The nature of the procedure is: Diagnosis and surgical treatment according to diagnosis.

The cause of this procedure is to cause permanent sterility.

**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 QUADRIPLÉGIA, 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:

1. Failure to become sterile – that is, I could either become pregnant in my Uterus (womb) or have an ectopic pregnancy (In my tube or other site)
2. Injury to bowel, bladder, ureter and the vagina and/or skin), requiring a second operation to repair the fistula.
3. Major surgery - Requiring colostomy or possible removal of uterus, tubes and/or ovaries
4. Necessity for an exploratory laparotomy (opening the abdomen) to either complete the laparoscopy procedure or repair any Injury.
5. Blood loss necessitating transfusion, which carries the risk of exposure to AIDS or the hepatitis virus.

**No guarantee for success is given.**

**Prognosis:** If I choose not to have the above procedure, I might still become pregnant.

Alternative forms of treatment include:

1. Diaphragm
2. Birth control pills
3. Intrauterine devices (IUD)
4. Barrier methods (use of foams, condoms etc.)
5. Rhythm method
6. Abstinence
7. Vasectomy (male sterilisation)

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 Geysler and his associates / assistants to perform those additional procedures that they judge to be necessary.

BY SIGNING THIS FORM, I ACKNOWLEDGE 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 Geysler and his associated / assistants to proceed with surgery.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_