

## Consent for Hysterectomy

Please initial each line to show that you have read and understood each statement. I understand:

\_\_\_\_\_ That a **HYSTERECTOMY** (his-ster-eck-toe-me) is an operation that removes the entire uterus (womb). The uterus is removed through an incision made in the lower abdomen (Abdominal Hysterectomy) or through the vagina (Vaginal Hysterectomy). Sometimes more surgery is needed to remove or repair other organs as needed (ovaries, tubes, appendix, bladder, rectum or vagina.)

\_\_\_\_\_ That removal of the uterus is permanent and cannot be reversed. Once the uterus removed, you will not longer be able to get pregnant.

\_\_\_\_\_ I may consult with another doctor about my need for this surgery.

\_\_\_\_\_ Alternate treatment choices that were discussed about my condition.

\_\_\_\_\_ Do nothing and accept the natural course of the disease process.

\_\_\_\_\_ Attempt to control some problems with hormones or other drugs.

\_\_\_\_\_ Use radiation / x-ray therapy for treatment.

\_\_\_\_\_ Attempt to remove the diseased or abnormal tissue and to repair what is left behind.

\_\_\_\_\_ Use a device for support of female organs

\_\_\_\_\_ Attempt to control symptoms through other types of surgeries (D&C, hysteroscopy, LASER or biopsy)

\_\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ The main reasons for having this surgery are as listed below ; however the final outcome may differ and cannot be guaranteed:

\_\_\_\_\_

\_\_\_\_\_ It is not possible to predict all possible risks.

### Risks include but are not limited to:

\_\_\_\_\_ Nausea, vomiting, pain, bleeding, infection, poor healing, hernia, formation of scar tissue.

\_\_\_\_\_ Injury to other organs (e.g. tubes, ovaries, bowel, bladder or ureter(s) (tubes from kidney to bladder).

\_\_\_\_\_ Injury to nerves going from the pelvis to the legs

\_\_\_\_\_ Blood clots that form in the legs or lungs.

\_\_\_\_\_ Other risks may occur from any drugs that are used.

\_\_\_\_\_ There is no guarantee that surgery will cure or improve symptoms. In rare cases, symptoms may get worse.

\_\_\_\_\_ Other problems or conditions may be caused by having this procedure. These include but are not limited to:

\_\_\_\_\_

\_\_\_\_\_ Limits on physical and sexual activity will be needed and that the timeframe will be decided by my doctor.

\_\_\_\_\_ Pain control may be done with local, regional or general anesthesia. I will discuss with the anesthesiologist the risks of the type of pain control that is best for me. I understand I will sign a separate consent form with this doctor about pain control.

\_\_\_\_\_ My stay in the hospital will be for about \_\_\_\_\_ days, and it may take 4-8 weeks to recover fully.

I have read this consent and have had all my questions answered. I give my consent to Dr. \_\_\_\_\_ to perform this surgery.

Patient Signature: \_\_\_\_\_

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

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

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