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Office Procedure Consent

Patient Name: _____ DOB: _____
I hereby authorize my physician/nurse practitioner/physician assistant to perform upon me (or the above named patient) the following procedure(s):

____ Colposcopy

____ D&C Hysteroscopy

____ D&E

____ Endometrial Biopsy

____ Excision/Biopsy/I&D

____ Nexplanon Insertion

____ Nexplanon Removal

____ IUD Placement (Kyleena, Liletta, Mirena, Skyla, Paragard)

____ IUD Removal (Kyleena, Liletta, Mirena, Skyla, Paragard)

____ LEEP

____ Minerva

____ NovaSure

____ Other

I acknowledge that my practitioner has fully and completely explained the following to me with regards to the procedure(s) to be performed:

1. **The nature of the procedure(s) to be performed.**
2. **Risks associated with the procedure(s), including those associated with not having the procedure(s) performed.**
3. **Alternatives to the procedure(s).**

I have been advised that the risks involved include, but are not limited to:

____ Blood loss
____ Infection
____ Uterine Perforation
____ Possible damage to other organs**.**

If I have any of the following conditions, I will notify you prior to the procedure(s), as it may mean the procedure(s) should not be done at this time.

____ Severe Anemia

____ Extreme Anxiety

____ Clotting Mechanism Deficiency

____ Pelvic Infection

____ Heart Disease (do you take antibiotics prior to dental procedures)

____ Other Health Conditions

____ Possible Pregnancy

I have been given the opportunity to ask questions about my condition and the nature, risks and alternatives to the contemplated procedure(s). I make this consent knowingly and voluntarily. I acknowledge that no guarantee or assurance has been made relative to the success or outcome of the procedure(s) to be performed.

_____

Patient Signature Date

In the event the patient is an unemancipated minor is unable to sign for the following reason(s): i.e. medical emergency, patient is unconscious, incompetent, etc.

_____

Relative/Representative Signature Relationship Date

Physician Attestation Statement:

The above referenced patient has been provided with the explanation of the material risks and likely complications that are or may be associated with the procedure(s)/treatment, benefits, alternatives if any, including the likely outcome of not having the procedure(s)/treatment.

_____

Provider Signature