| BRONSON | Affix Patient Label |
|---|---|
| | Patient Name: Date of Birth: |

This information is given to you so that you can make an informed decision about having **laparoscopic hysterectomy.**

**Reason and Purpose of the Procedure:**

You and your doctor have decided it would benefit you to remove your uterus. This operation is called a hysterectomy. The most common reasons for a hysterectomy are fibroid tumors, endometriosis, uterine prolapse, cancer and bleeding that is not normal.

A laparoscopic hysterectomy involves several small incisions, or cuts, in your abdomen. The laparoscope and other tools will be inserted through the incisions in the abdomen. The tools are used to detach the uterus. Specialized instruments are inserted and used for the removal process.

In some cases the fallopian tubes and ovaries may be removed. This procedure is called a salpingo/oophorectomy.

After this procedure you will not be able to become pregnant nor have children in the future.

**Benefits of this surgery:**
You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Relief of your symptoms you are experiencing
- Improve your quality of life
- Treat cancer or precancerous conditions

**Risks of Surgery:**
No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

**General Risks of Surgery:**

- Small areas of the lungs may collapse. This would increase the risk of infection. This may need antibiotic and breathing treatments.
- Clots may form in the legs, with pain and swelling. These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- A strain on the heart or a stroke may occur.
- Bleeding may occur. If there is too much bleeding, you may need a transfusion.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The Anesthesiologist will discuss this with you.

**Risks of this surgery**

- The incision site may become infected. This may require antibiotics and wound care. Rarely, the incision may open and need more surgery.
- Bleeding during or after the procedure. This may need a blood transfusion.
- Injury to the bowels and/or bladder/ ureter. This may need surgery to repair.
- Injury to the surrounding blood vessels may occur. This may need further surgery to repair.
- There may be a hernia or rupture at the site of the incision or into the vagina. This may require surgery

- Damage to the nerves. You could have weakness, numbness, tingling and pain in the thighs, legs and feet.
- The vagina may change shape. It may become shorter or the angle may change. This may result in painful intercourse.
- You may show signs of menopause such as mood swings and hot flashes.
- You may have an increased risk for developing osteoporosis (when bones become less dense and are more likely to break

**Risks Associated with Smoking:**
Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

**Risks Associated with Obesity:**
Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

**Risks Specific to You:**

_____
_____
_____
_____

**Alternative Treatments:**
Other choices:

- Do nothing. You can decide not to have the surgery.
- Ask your doctor about medical therapies.

**If You Choose Not to Have this Treatment:**

- Continue to manage your symptoms either on your own or with your doctor.

**General Information:**

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

| BRONSON | Affix Patient Label |
|---|---|
| | Patient Name: Date of Birth: |

**By signing this form I agree:**

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Laparoscopic Hysterectomy □ Robotic □with bilateral salpingo/oophorectomy**_____
  _____
  _____
- I understand that other doctors, including medical residents, or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

**Provider:** This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature_____Date:_____Time:_____
**Relationship: □Patient □Closest relative (relationship)_____ □Guardian**

**Interpreter's Statement:** I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter:_____Date_____Time_____
Interpreter (if applicable)

**For Provider Use ONLY:**
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider Name: _____

Provider signature: Date: Time:

**Teach Back**

Patient shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____
Or
____ Patient elects not to proceed: _____ (patient signature)

Validated/Witness:_____Date:_____Time:_____