BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Informed Consent Anterior and/or Posterior Colporrhaphy

This information is given to you so that you can make an informed decision about having an **anterior and/or posterior colporrhaphy.**

Reason and Purpose of the Procedure:
Colporrhaphy is a repair of the walls of the vagina. It can be done on the anterior (front) and posterior (back) walls.

- Anterior colporrhaphy treats a weakness in front of the vagina (**cystocele)**.
- Posterior colporrhaphy treats a weakness in the posterior wall of the vagina (**rectocele)**.

The reason for this surgery is because the symptoms of prolapse have become bothersome in your daily life.
This operation involves surgical incisions (cuts) in the front and/or back walls of the vagina.

Benefits of this Procedure:
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 symptoms you are experiencing

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 antibiotics 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.
- Bleeding may occur. If excessive you may need a blood transfusion.
- Reaction to the anesthetic. 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 be treated with antibiotics.
- Bleeding during or after the procedure. This may need a blood transfusion.
- Injury to the bowels and/or bladder. This may need surgery to repair. Sometimes this can be diagnosed right away. Sometimes it may take several days.
- You may develop a urinary tract infection. This may be treated with medications.
- 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.
- The organs in your lower belly (bladder, urethra, and rectum) could slip out of place again. This could need more treatments.
- Abnormal openings between the vagina, bowel, and bladder may form. One example of this would be urine leaking from the vagina. This would need surgery to correct.

- Difficulty holding your urine. This could get better after surgery. It could also get worse.

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. It increases the risks of failure for this procedure.

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. It increases the risks of failure for this procedure.

Risks Specific to You:

_____
_____
_____
_____

Alternative Treatments:
All treatments have risks. Talk with your doctor about these choices.

- You can decide not to have this surgery.
- Talk with your doctor about other surgeries.
- Talk with your doctor about using a pessary. This is a plastic or rubber ring that's inserted in the vagina. This supports the bladder by pushing it up and back into place.
- Talk with your doctor about a referral for pelvic floor physical therapy.

If You Choose Not to Have this Treatment:

- Your health care provider will continue to monitor your symptoms.

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.

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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: ☐**anterior** ☐**posterior colporrhaphy.**

  _____
- I understand that my doctor may ask a partner to do the surgery.
- 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 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:_____