Affix Patient Label

Patient Name: ___________________________________ Date of Birth: __________________________

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

Reason and Purpose of the Procedure:

Myomectomy is surgery to remove uterine fibroids. They are growths of the uterus. Your doctor might suggest this procedure when your fibroids cause trouble in your everyday life.
This can be done three different ways:

- Hysteroscopy: Is surgery within the uterus. A small scope and small surgical tools will be used.
- Laparoscopy: Is surgery through the belly with small incisions (cuts). A small scope is used to see inside. Small surgical tools will be used.
- Laparotomy: Is surgery with an incision (cut) in the belly.

The size and type of fibroids helps the doctor to choose the right way. The fibroids will be sent for testing.

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.

- Improvement of your symptoms.
- Could improve the chance getting pregnant.
- Could help your doctor to diagnosis your problem.

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 may occur.
- Bleeding may occur. If bleeding is excessive, 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.

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Risks of this surgery:

- **Infection:** The incision site may become infected. This may require antibiotics and wound care. Rarely the incision may open and need more surgery.
- **Bleeding:** This may occur during or after the procedure. This may require a blood transfusion.
- **Injury:** There may be injury to the bowel, bladder, and ureters. This will require surgery.
- **Growth of new fibroids:** Tiny tumors (seedlings) that your doctor cannot see during surgery could grow back.
- **Unable to rebuild the uterus:** To remove some fibroids, the doctor may need to cut into the muscular wall (myometrium) of the uterus. This could leave a gap. Closing it needs stitches. Rarely the doctor will have to remove the uterus.
- **Scar Tissue Formation:** Scar tissue can form within the belly or within the area of the uterus. This may make pregnancy difficult.
- **Need for Cesarean Section:** Your doctor might recommend a Cesarean section (C-section).
- **Weakness/numbness in Arms and Legs:** This is related to your position during surgery. Usually this does not last long.
- **Fluid Imbalance (only with hysteroscopic myomectomy):** Your doctor will carefully monitor your fluids. Fluid imbalance happens rarely.

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:

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

If you choose not to have this treatment:

- Fibroids often grow. This will make your symptoms worse.
- Your health care provider will continue to monitor your symptoms.

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Patient Name: ________________________Date of Birth: ____________

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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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: **Myomectomy** (check one)
  - ☐ Hysteroscopic
  - ☐ Laparoscopic
  - ☐ Laparotomy

  ____.
- 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/products.

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 (if applicable) *Date* *Time*

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:__________