



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent Salpingo Oophorectomy

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

Reason and Purpose of the Procedure:

Oophorectomy is a surgical procedure to remove one or both of your ovaries. Reasons to have this procedure are:

- Ovarian cancer
- Abscess (a pocket of infection)
- Endometriosis (tissue that normally lines your uterus grows outside the uterus)
- A twisted ovary (torsion)
- Non-cancerous tumors or cysts
- May lower the risk of breast cancer from happening again
- Testing shows an increased risk of ovarian cancer

The surgery is done by making an incision (cut) in the lower part of the abdomen. It may also be done with a laparoscope. This way, smaller incisions (cuts) are made. The laparoscope and other tools are inserted through the incisions to remove the ovaries.

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.

- Less discomfort in your abdomen.
- Lower risk of ovarian cancer.
- May lower the risk of breast cancer re-occurrence

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.



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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.
- Difficulty holding your urine. This could get better after surgery. It could also get worse.
- 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.
- Your provider may need to change to an open procedure. This may cause a larger incision, other procedures or lengthen your recovery.

Risks of this surgery:

- **Infection:** The incision site may become infected. This may require medication 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 other organs, nerves, and blood vessels. This may need other surgery and/or treatments to repair. Sometimes this can be diagnosed right away. Sometimes it may take several days.
- **Ruptured tumor:** For women who have tumors, cells from the tumor might spill into the body.
- **Ovarian Remnant Syndrome:** This is when ovary cells continue to cause symptoms like pelvic pain.
- **Premature Menopause:** For women who have not had menopause, if both ovaries are removed, this will cause early menopause. You may experience hot flashes, night sweats, depression and mood swings. You may have changes in your sexual health. There may be other health risks that occur. Your provider will advise you on options for your symptoms.

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:



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Alternative Treatments:

- Do nothing. You can decide not to have the procedure.
- Ask your doctor about options. There may be medical therapies that would be helpful.

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: **Salpingo Oophorectomy possible open:** laparoscopic laparotomy
 right left
-
- 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: _____