BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Informed Consent Loop Electrode Excision Procedure (LEEP)

This information is given to you so that you can make an informed decision about having Loop Electrode Excision Procedure (LEEP).

Reason and Purpose of the Procedure:

When cells that might cause cancer grow on the cervix, this is called "cervical dysplasia". LEEP can help treat and possibly cure this condition by taking out the abnormal cells that are pre-cancerous from your cervix. LEEP uses a thin wire electrode. The thin wire is attached to an electrosurgical generator. The generator transmits electric current. Cervical tissue within the loop is cut away.

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.

- Removal of abnormal tissue from the cervix
- In many cases it treats your condition so you may not need another procedure
- It gives your doctor more information about your condition and how to treat you

Risks of Procedure:

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.

Risks of this procedure:

- Your cervix may become infected, requiring medication to treat your condition.
- Injury to the vagina or nearby organs can occur. Surgery may be needed to fix such an injury.
- Heavy bleeding during and/or after the procedure. In rare cases a blood transfusion may be needed.
- Mild pain
- Incomplete removal of abnormal tissue
- Some of the abnormal cells may be left behind and may require more treatments
- There is a minor increase in the possibility of complications related to future pregnancies

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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 can also increase the risk of cervical cancer.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Laser Ablation. Lasers produce a hot, completely focused beam of light, which can remove or vaporize tissue and control bleeding. A biopsy cannot be sent to the lab for testing because the tissue is destroyed.
- Cryoablation
- Cold knife conization
- Do nothing. You can decide not to have the procedure.

If you choose not to have this treatment:

- There is a risk that it could get worse and spread which would require a more serious surgery such as a hysterectomy.

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: **Loop Electrode Excision Procedure (LEEP)**

  _____
- 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:_____