DISCLOSURE AND CONSENT FOR MEDICAL & SURGICAL PROCEDURES

Total Abdominal Hysterectomy / Supracervical Abdominal Hysterectomy with or without Bilateral Salpingo Oophorectomy

I have explained the procedure, risks, hazards, benefits, likelihood of achieving goals, alternatives, and risks to alternative therapy to the patient/legal representative.

Physician Signature: _____ Date: _____ Time: _____

TO THE PATIENT: You have the right, as a patient to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (We) voluntarily request Dr. _____
as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

_____

I (We) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize this procedure:

Total Abdominal Hysterectomy / Supracervical Abdominal Hysterectomy with or without Bilateral Salpingo Oophorectomy

I (We) understand that my physician may discover other or different conditions, which require additional or different procedures than those planned. I (We) authorize my physician, and such associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgment.

I (We) (☐ do) (☐ do not) consent to the use of blood and blood products as deemed necessary,

I (We) understand that there are risks and hazards related to transfusion, however unlikely, including, but not limited to, the following:

1. Fever
2. Transfusion reaction which may include kidney failure or anemia
3. Heart failure
4. Hepatitis

PATIENT IDENTIFICATION

5. AIDS (Acquired Immune Deficiency Syndrome)
6. Other infections

I (We) have been given an opportunity to ask questions, and my physician has explained possible alternative forms of treatment, the risk of refusing transfusion, the procedures to be used, and the hazards Involved.

I (We) (☐ do) (☐ do not) consent to have one or more observers, as requested by my physician, present in the room during my procedure. This may include equipment and/or supply vendors. I understand that all vendors present will have confidentiality agreements and that none of my personal health information will be disclosed to anyone other than my care givers within this facility.

I (We) (☐ do) (☐ do not) consent to the photographing/videotaping of surgical procedures being performed, including appropriate portions of my body, for medical, scientific, or educational purposes, providing my identity is not revealed by descriptive texts accompanying the pictures.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures is the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize that the following risks and hazards may occur in connection with this particular procedure:

1. Uncontrollable leakage of urine
2. Injury to bladder
3. Sterility
4. Injury to the tube (ureter) between the kidney and the bladder
5. Injury to the bowel and/or intestinal obstruction

Hysterectomy is the removal of the uterus through an incision in the lower abdomen or vagina. A hysterectomy is permanent and not reversible. Becoming pregnant or bearing children will no longer be possible.

I (We) understand that no warranty or guarantee has been made to me as to result or cure.

I (We) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, and that I (we) understand its contents.

DATE: _____ TIME: _____ am pm

_____
SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE)

_____
WITNESS (TO SIGNATURE ONLY)

_____
ADDRESS (STREET OR P.O. BOX)

_____
CITY STATE ZIP