CONSENT FOR COLPOSCOPY, BIOPSY, CROTHERAPY, OR LOOP ELECTRO SURGICAL EXCISION PROCEDURE (LEEP)

The significance of an abnormal pap smear has been explained to me as indicating the presence of cells, which could develop into cancer. In order to further investigate the source of the abnormal cells and determine the type of treatment most suitable, I understand that examination of my cervix with a magnifying instrument called a colposcope is recommended.

I also understand that small tissue specimens called biopsies any be taken from the vulva, vagina, or cervix, and a tissue scraping, called an endocervical curettage, may be taken from just within the cervix. I understand that this a surgical procedure that carries a slight risk of bleeding. I also understand that the biopsies taken will be sent for microscopic examination and then will be stored or disposed of in a proper fashion.

If cryosurgery is recommended, I realize that cryoprobe will be used to freeze my cervix. I have been instructed to avoid sexual intercourse, douching, and tampons until the following-up examination in two weeks. I realize that there is a small chance that cryosurgery could cause bleeding or a pelvic infection. The warning signs of these have been explained to me.

I also understand that cryosurgery does not cure all patients with my condition. I have been informed that the recurrence rate for lesions treated with cryotherapy is from 5% - 10%. I understand that frequent follow-up examinations with colposcopy and/or pap smears are essential in order to determine which patients have a persistent problem and require additional evaluation and treatment. I understand dysplasia of the vulva, vagina, or cervix can progress to become cancer if it is not detected early.

If Loop Electrosurgical Excision Procedure (LEEP) is recommended, I realize that a Loop Electrode will be used to allow for excision of the entire transformation zone & many cervical intraepithelial neoplastic lesions.

I have been instructed to refrain from sex for three to four weeks and to avoid heavy lifting. I understand that brownish-black discharge for a few days to two weeks is normal. If spotting, bleeding, or odor persists more than six days, I am to call my physician. Recheck appointment is to be made___months from date of procedure.

- ***Alternative Methods of Treatment*** *I am satisfied with my understanding of specific risks of this procedure or treatment including (Physician to describe specific risks where applicable)*

  _____
  _____
- ***No treatment*** *I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.*
- ***No Guarantees*** *I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.*
- ***Other Questions*** *I am satisfied with my understanding of the nature of the procedure or treatments and all of my additional questions about the treatment or procedure have been answered.*

These procedure have been explained to me in detail, and I consent to let Dr. Morris Ahdoot perform_____.

Signature_____Date_____ Signature of Witness_____