Rahil Malik MD, Fellow of American College of Obstetrics and Gynecology

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Date of Procedure

COLPOSCOPY CONSENT FORM Name, DOB

I hereby request and authorize Dr **Malik** to perform upon me the procedure: **colposcopy with or without single or multiple biopsies of cervix and/or walls of the vagina, endocervical curettage (ECC), destruction of lesion(s)**.

Description: This procedure involves the use of a lighted microscope, called a colposcope, designed to give a magnified view of tissue lining the cervix and vagina. A speculum will be inserted into the vagina, a mild solution of acetic acid (vinegar) is swabbed on the cervix to wash away mucous secretions and highlight abnormal areas on the surface. Your doctor will determine whether to proceed with collection of biopsy sample(s) or not after performing a visual examination.

Indication: The procedure may be used to diagnose infections, inflammatory, pre-malignant, malignant, or other conditions affecting the cervix and/or vaginal walls.

Risks include: *bleeding, infection, mild/moderate discomfort, scarring, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition.*

Benefits may include: achieving a diagnosis and/or alleviating symptoms.
Alternatives include: not doing the procedure.

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment. My signature below certifies that:

1. I have read the above authorization and consent and have been provided the opportunity to ask questions.
2. The proposed procedure(s) including their potential benefits and complication or side effects, problems that may occur during recuperation and the likelihood of achieving expected goals have been explained to me.
3. I understand that I have the right to refuse any medical or surgical procedures or treatment.
4. I certify that I have read and fully understand the above consent and have no further questions which I need answered prior to the procedure.

_____ Date of Procedure _____

Patient Signature Date

_____ Date of Procedure _____

Witness signature (Medical Assistant) Date

_____ Date of Procedure _____

Dr **Malik** Signature Date