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

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Date of Procedure

Hysteroscopy (Endosee) and Endometrial Biopsy (EMB) CONSENT FORM

I Name, DOB_____hereby request and authorize Dr **Malik** to perform upon me the procedure: **Hysteroscopy with Endosee and Endometrial biopsy.**

Description: A hysteroscope (a small tool with a video camera) is used to visualize the interior of the uterine cavity. It allows the physician to identify abnormalities such as polyps, fibroids, thickened endometrial lining and allows removing a small piece of endometrium (uterine lining) using a special catheter for pathologist evaluation. A speculum is inserted into the vagina and the cervix is cleansed with an antiseptic solution. Lidocaine is given for pain control. A special catheter is then placed into the uterus, and a small piece of the uterine lining is removed via the catheter.
Indication: The procedure may be used to diagnose the causes of abnormal uterine bleeding and/or to evaluate conditions that may affect a patient's ability to get pregnant or carry a pregnancy to term. **Risks** include: bleeding, mild/moderate cramping, infection, scarring, failure to diagnose the condition, allergic reaction to antiseptic solution used to cleanse the cervix, disruption of a pregnancy, side effects of Lidocaine medication, perforation of the uterus, and/or rarely a pelvic infection.
Benefits may include: achieving a diagnosis , removal of a polyp, obtaining tissue to diagnose endometrial abnormalities etc.
Alternatives include: not doing the procedure, trial of medical treatment, hysterectomy.

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 and 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