

LEEP CONSENT FORM FOR:

hereby request and authorize Dr **Malik** to perform upon me the procedure: **loop electrical excision procedure of the cervix (LEEP PROCEDURE)**.

Brief Description: This procedure involves using a fine wire loop with low-voltage electrical current to remove, or excise, a cone-shaped biopsy of cervical tissue. A speculum is inserted into the vagina, a mild solution of acetic acid (vinegar) is swabbed on the cervix to wash away mucous secretions and to highlight abnormal areas on the surface. Examination with a colposcope will then be performed and the locations for the excision determined. A local anesthetic will be injected into the cervix, sometimes mixed with a medication to help control bleeding. The loop is carefully drawn across the cervix to remove a thin layer of the cervix to submit to pathology for examination. Occasionally there is bleeding from the cut surface of the cervix, your care provider may use electrical cauterization or apply a liquid or paste-like solution (Monel's) to the bleeding areas to stop the bleeding. When adequate amount of specimen has been collected and bleeding is controlled, the procedure will be complete and the speculum will be removed.

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, cramping, scarring, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition, cervical stenosis, cervical insufficiency, injury to the vagina, bladder, or rectum.

Benefits may include: achieving a diagnosis and/or alleviating symptoms.

Alternatives include: not doing the procedure, cryotherapy.

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.

Patient Signature

Date

Witness signature (Medical Assistant)

Date

Dr **Malik** Signature

Date