TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
DISCLOSURE AND CONSENT MEDICAL AND SURGICAL PROCEDURES

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.

1. I (we) voluntarily request Doctor(s) _____ as my physician(s), 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 (lay terms).
   Abnormal Cells of the Cervix

2. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures; (lay terms)
   (Loop Electro Excision Procedure (LEEP) and Cervical Conization Procedure)
   the removal of tissue from all around the cervix by using electric current.

3. 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.

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

5. 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 are 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:
   Bleeding, infection, cervical stenosis, infertility, loss of cervical mucus, incompetent cervix, increase adverse pregnancy outcome, recurrence of abnormal cells of the cervix.

6. I (we) understand that anesthesia involves additional risks and hazards but I (we) request the use of anesthetics for the relief and protection from pain during the planned and additional procedures. I (we) realize the anesthesia may have to be changed possibly without explanation to me (us).

   I (we) understand that certain complications may result from the use of any anesthetics including respiratory problems, drug reaction, paralysis, brain damage or even death. I (we) understand that other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

7. I (we) authorize Texas Tech University Health Sciences Center to preserve for educational and/or research purposes, or to otherwise dispose of any tissue or parts removed except _____
   _____

8. I (we) consent to the taking of still photographs, motion pictures, videotapes, or closed circuit television during this procedure. These will remain the property of the individual physician and/or Texas Tech University Health Sciences Center and will not become part of the medical record.

9. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of no treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

10. I (we) certify this form has been fully explained to me by Doctor _____ that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

IF I (WE) DO NOT CONSENT TO ANY OF THE ABOVE PROVISIONS, I (WE) HAVE CROSSED OUT THAT PROVISION OR PROVISIONS, DATED AND SIGNED THE CROSSED OUT PORTION (S).

DATE: _____ TIME: _____ A.M. P.M.

PHYSICIAN'S SIGNATURE_____

_____
PATIENT/OTHER LEGALLY RESPONSIBLE PERSON SIGNATURE

_____
WITNESS SIGNATURE

_____
PRINT NAME AND RELATIONSHIP

_____
PRINT NAME

Translated into _____/Read to Patient by:

_____
Signature

Print Name _____