advocare | Montgomery Gynecology

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Consent for Endometrial Biopsy

INTRODUCTION: You have been scheduled for an Endometrial Biopsy. The reasons for performing this procedure is abnormal uterine bleeding and/or a thickened endometrial lining of the uterus. We are asking you to read and sign this form so that we can be sure you understand the procedure and potential benefits, along with the associated potential risks, complications, alternatives, the likelihood of achieving the goals, and the recuperative process. Please ask questions about anything on this form that you do not understand.

PROCEDURE: During this procedure, you will be in the same position you would be in for PAP smear. After your legs are positioned in the stirrups, a pelvic exam will be performed to determine the position of the uterus. A speculum will be inserted into your vagina and your cervix will be visualized. Following cleaning of your vagina and cervix, local anesthesia may be injected into the cervix and area will be grasped with a small instrument. A small tube or pipell is then inserted into the vaginal, through the cervix and into the uterus. A small sample of the uterus and uterus lining will be obtained.

RISKS: The specific risks associated with a endometrial biopsy include, but are not limited to: cramping, abdominal/pelvic discomfort, bleeding, infection, vaginal discharge, uterine perforation, and injury to the bowel or bladder.

ALTERNATIVES: There may be other ways to further evaluate your abnormal uterine bleeding and/or thickened endometrial lining of the uterus. If you are unsure about undergoing an endometrial biopsy, please discuss these possible alternatives with your physician.

AGREEMENT: The information on this form was explained to me by _____
I understand the information and I have had the opportunity to ask any questions that I might have regarding an endometrial biopsy, the reasons the procedure is being performed, the potential benefits, the associated risks and complications, and possible alternative forms of treatment. I agree to the procedure to be performed by_____. In addition, I agree to have any other personnel present for the procedure.

I understand that during this procedure, certain of my tissue(s), bodily substances and/or fluids may be removed and used, disposed of, or transferred by the Montgomery Gynecology for educational research purposes not specially related to my treatment.

Print Name:_____

Signature: _____ Date: _____
(Patient or Guardian)

Signature: _____Date: _____
(Physician)