advocare | Montgomery Gynecology

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Consent for Colposcopy and Cervical Biopsy

INTRODUCTION: You have been scheduled for a colposcopy and possible cervical biopsy. The reasons for performing this procedure are to further evaluate and abnormal PAP smear and/or cervical lesion (abnormal area). 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 speculum will be inserted into your vagina. Your cervix will then be examined through a microscope called a colposcope and photographs may be taken. Following cleaning of your cervix, if an abnormal area is identified, a biopsy may be performed. This involves taking a small sample of tissue from the abnormal area.

RISKS: The specific risks associated with a colposcopy and/or cervical biopsy include, but are not limited to: bleeding, infection and vaginal discharge. If a biopsy is performed, you may experience a pinching sensation or mild cramping as the sample of abnormal tissue is taken.

ALTERNATIVES: There may be other ways to further evaluate your abnormal PAP smear and/or cervical lesion. If you are unsure about undergoing a colposcopy and possible cervical 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 a colposcopy and possible cervical biopsy, the reasons the procedure is being performed, the potential benefits, the associated risks and complications, and possible alternative forms of treatment.

Print Name:_____

Signature: _____Date: _____
(Patient or Guardian)

Signature: _____  _____ Date: _____
(Physician)