Loop Electrosurgical Excision Procedure (LEEP) Consent Form

_____ I have been informed that during the course of the procedure, unanticipated conditions may occur which may extend the procedure or prevent it from being completed.

_____ I understand and have given my consent to use medication to provide adequate comfort during the procedure to allow it to be performed (local anesthetic).

_____ I understand this procedure is intended for the treatment of abnormal cells of the cervix. The expectation is to achieve normal cervical tissue. Slightly more than 98% of the time, this is achieved.

_____ I understand this procedure is not recommended if any of the following conditions are present: Pelvic infection, invasive cancer, or pregnancy.

_____ I understand possible complications include, but are not limited to the following: Heavy bleeding, incomplete removal of abnormal tissue, infection, narrowing of the cervical opening, vasovagal reaction (dizziness, clamminess, of skin, faint feeling, or fainting), pain or severe cramping during or after the procedure, a weakened cervix that could cause problems during pregnancy, accidental cutting or burning of normal tissue, or fertility problems.

_____ I have been informed as to how the procedure will be performed. I have received information about the procedure and about alternative treatments. I have been allowed to ask any question regarding this procedure or any other treatment options.

I authorize Dr. _____ to perform a Loop Electrosurgical Excision Procedure (LEEP).

_____

Patient Signature Date

_____

Witness Date