Document Type: Consent Forms

CST003

Methodist Hospital
Methodist Women's Hospital

METHODIST HEALTH SYSTEM

CONSENT TO SURGERY, SPECIAL DIAGNOSTIC OR MEDICAL PROCEDURE

Electro-Mechanical Morcellation (EMM)

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure so that you may make the decision whether or not to undergo the procedures after knowing the risks involved and any treatment alternatives available to you. This information is not meant to alarm you; it is an effort to make you better informed so that you may give or withhold your consent to the procedure. If you do not understand any of the information provided, ask your physician to explain it.

1. **DIAGNOSIS:** I voluntarily request my physician, _____ M.D. and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my CONDITION: _____
_____

2. **PROCEDURE(S):** I understand that the following surgical, medical and/or diagnostic procedure(s) are proposed for me. I voluntarily consent to and authorize this (these) procedure(s)

_____

_____

3. **MATERIAL RISKS:** I understand there are risks related to the performance of the surgical, medical and/or diagnostic procedure planned for me. I realize that common risks to surgical, medical and/or diagnostic procedures include but are not limited to infection, blood clots in veins or lungs, bleeding, allergic reaction and even death. I also realize that the following additional RISKS may occur in connection with this (these) procedure(s)

   - EMM or electro-mechanical morcellation can cause tissue fragments to spread into surrounding structures if undiagnosed gynecologic cancer is present in the specimen

4. **CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS:** I understand that my physician may encounter or discover other or different conditions which require additional or different procedures than those planned. I authorize my physician and other health care providers to perform such other procedures, which are advisable in their professional judgment.
5. **OUTCOME:** I understand that no guarantee or assurance has been made to me as to the results that may be obtained.

CONSENT:

I have been given sufficient opportunity to ask questions about my condition, alternative treatments, the surgical, diagnostic and/or medical procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I have sufficient information to give this informed consent to the above-described procedure.

I acknowledge that this form has been fully explained to me, and that I have read it, or have had it read to me.

_____ _____
Signature of Patient or Legally Responsible Person Date

_____ _____
Signature of Physician Time (A.M./P.M.)

Patient Label

PERMANENT PART OF MEDICAL RECORD