Augusta Health Care for Women

Informed Consent for Cryosurgery of Cervix

I hereby request and authorize (Care Provider) _____to perform upon me the procedure: ***cryosurgery of the cervix.***

This procedure involves using freezing temperature to destroy abnormal cervical tissue. A speculum is inserted into the vagina. Once the area is visualized, a metal tipped probe is placed against the abnormal tissue. The freezing agent (liquid nitrogen) then flows through the probe and the freezing temperature is passed through the metal to the surface of the cervix. The freezing is performed with either a "double-freeze" technique (freeze, thaw, freeze), or a single, slightly longer, freeze cycle. Once the freeze cycle(s) are finished, the procedure is complete.

The goal of the procedure is to treat abnormalities of the cervix initially discovered by pap testing and confirmed by colposcopy and cervical biopsy.

Risks include**: infection, mild/moderate discomfort, cramping, scarring, failure to diagnose or cure the underlying condition, persistence or recurrence of the condition, cervical stenosis, injury to the vagina.**

Benefits may include: achieving a diagnosis and/or alleviating symptoms.

Alternatives include: not doing the procedure, loop electrical excision procedure (LEEP).

I have been advised of the nature and purpose of the proposed surgical procedure(s), the nature of my condition, alternative types of treatment and the prognosis with vs. without treatment.

My signature below certifies that:

1. I have read the above authorization and consent and have been provided the opportunity to ask questions.
2. The proposed procedure(s) including their potential benefits and complication or side effects, problems that may occur during recuperation and the likelihood of achieving expected goals have been explained to me.
3. I understand that I have the right to refuse any medical or surgical procedures or treatment.
4. I certify that I have read and fully understand the above consent and have no further questions which I need answered prior to the procedure.

_____ _____ _____

Patient's Signature Date/Time Representative (if minor or incompetent)

_____ _____

Witness Date/Time

_____ _____

Care Provider Signature Date/Time