Las Vegas Urogynecology

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Physician's Surgical Procedure Disclosure and Patient's Consent

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 procedure 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 to you.

1. **DIAGNOSIS:** I (we) voluntarily request my physician, Victor E. Grigoriev, MD, and such associates, technical assistants, and other health care providers as they may deem necessary, to treat my CONDITION:

   PELVIC ORGAN PROLAPSE; URINARY INCONTINENCE

   (MAY INCLUDE ALL OR SOME OF THE FOLLOWING STRUCTURES:

   CYSTOCELE - BLADDER PROLAPSE, RECTOCELE - RECTUM PROLAPSE,

   VAULT – VAGINAL WALLS PROLAPSE, UTERINE PROLAPSE).

   THIS MEANS weakness of supporting tissue of bladder, rectum and vagina, with falling

   of the bladder, rectal walls, OR UTERUS through the vagina.

2. **PROCEDURE(S):** I (we) understand that the following surgical procedure(s) are planned for me on or about (month) _____(day) _____ (year) _____. I voluntarily consent to and authorize this (these) PROCEDURE(S) for the following purpose(s):

   ROBOTIC ASSISTED LAPAROSCOPIC SACROCOLPOPEXY

   (REPAIRING WEAKNESS OF THE SUPPORTING STRUCTURES WHICH MAY HAVE RESULTED IN PELVIC ORGAN PROLAPSE)

   HYSTERECTOMY (REMOVAL OF THE UTERUS WITH POSSIBLE REMOVAL OF THE OVARIES AND TUBES.)

PROPOSED BENEFITS:

Benefits may include relief of symptoms caused by weakness of the wall of the vagina, bladder and rectum.

PROCEDURE ANATOMICAL LOCATION:

Through four to five less-than-an-inch openings in the abdomen.

In five% of patients, incision will have to be made in the abdomen or vagina to accomplish an operation.

3. MATERIAL RISKS: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks related to the performance of the surgical, medical and/or diagnostic procedure(s) planned for me, including:

- Poor healing of vaginal wall over the material used to support the weakened wall. This occurs in 3-5% of surgeries, and at times, requires additional procedure to repair non-healing wound, either in office or in hospital.
- Urinary incontinence (loss of urinary control) which may require additional procedure (3-8%).
- Damage to rectal and/or bladder wall (less than 1%)
- Fistula (abnormal opening between rectum and bladder to vagina).
- Recurrence of weakness in supporting tissues (1-5%).
- Urinary retention requiring drainage by catheter.
- Discomfort with intercourse if sexually active.
- Bleeding.
- Blockage of ureters (tubes leading to and from the bladder).
- Anesthetic or cardiovascular problems during or after surgery.
- Pain or hernia formation in the incision area, possibly requiring surgery.
- Bleeding or hemorrhage with need for transfusion of blood products.
- Infection of incision, requiring further treatment or surgery.

Any of these complications may lead to additional surgical procedures at a later date.

Additional material risks of surgical, medical and/or diagnostic procedure(s) include: death, cardiac arrest, brain damage, disfiguring scar, paralysis or partial paralysis, loss or loss of function of a limb or organ, blood clots in veins or lungs, severe loss of blood, allergic reaction and infection.

4. **ALTERNATIVES TO PROCEDURE:** The following practical alternatives to this procedure have been discussed with me:

   Use of a fitted pessary (device placed into the vagina to keep pelvic organs in place), Kegel excercises, manual assistance for stool evacuation using digital, intravaginal pressure, observation.

   Open abdominal incisional surgery or vaginal surgery.

5. **LIKELY OUTCOME IF NO TREATMENT:** I have been informed of the likely outcome if no treatment is provided, as follows:

   Condition usually worsens with further organ prolapse, difficulty urinating, pelvic discomfort, vaginal pain, difficulty with bowel movements.

   But, the condition is not life threatening.

6. ANESTHESIA: I (we) understand that anesthesia involves additional risks but I (we) request the use of an anesthetic for the relief and protection from pain during the planned and additional procedure(s), if any. I (we) realize the anesthesia may have to be changed without explanation to me (us).

I (we) understand that certain complications may result from the administration of anesthesia. Common side affects include, but are not limited to: nausea, vomiting, pain where injection is given, injury to blood vessels. Although rare, unexpected severe complications with anesthesia can occur and include the possibility of infection, bleeding, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death. Other risks and hazards which may result from the use of general anesthetics range from minor discomfort or injury to the vocal cords, mouth, teeth or eyes to pneumonia. I (we) understand other risks and hazards resulting from spinal or epidural anesthetics include headaches, backaches, persistent weakness, numbness and chronic pain. I (we) understand other risks and hazards resulting from a major/minor nerve block include weakness, persistent numbness and residual pain. I (we) understand other risks and hazards resulting from moderate sedation/analgesia, also called conscious sedation, include retrograde amnesia (inability to remember the procedure), depressed blood pressure and depressed breathing rate.

Additional anesthesia information supplied to the patient:

_____
_____
_____

[ ] Anesthesia is to be administered by or under the direction of an Anesthesiologist

OR

[ ] Anesthesia is to be administered by _____

7. TREATMENT LIMITATIONS: I impose no specific limitations or prohibitions regarding treatment other than those that follow:

[If none, so state.]

_____
_____
_____

8. DISPOSAL OF TISSUE: I (we) authorize the disposal of any surgically removed tissue or parts resulting from the procedure according to accustomed practice.

9. BLOOD PRODUCTS: I (we) understand that if blood products are required, their use may improve my overall condition or save my life. I (we) understand that certain complications may result from the use of blood products. The more common risks include (but are not limited to) infection/irritation where the needle is placed, fever, chills, and skin rashes. Other rare but more serious complications may occur such as allergic reactions, shock, or death. I also know there is a very small risk of infection, including the risk of hepatitis (<1 in 200,000) and/or HIV/AIDS (<1 in 2 million).

[ ] I (we), consent to the use/administration/transfusion of blood products as deemed necessary.

[ ] I (we), do not consent to the use/administration/transfusion of blood products as deemed necessary.

10. CONSENT TO TREATMENT OF UNFORESEEN CONDITIONS: I (we) understand that my physician may encounter or discover other or different conditions which require additional or different procedures than those planned. I (we) authorize my physician, and associated technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

11. OUTCOME: I (we) understand that the practice of medicine is not an exact science, and that no warranty or guarantee has been made to me as to result or cure.

12. CONSENT TO TRAINING PARTICIPATION: This facility may have an educational role in the training of paramedical personnel.

Admittance of students and/or technical representatives

[ ] I (we) consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

[ ] I (we) do not consent to the admittance of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

Participation of students and/or technical representatives

[ ] I (we) consent to the participation of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

[ ] I (we) do not consent to the participation of students and/or technical representatives for the purpose of advancing medical education and/or product usage.

13. PHOTOGRAPHY: I (we) agree that still or video photography, audio recordings, or medical data may be taken during these treatments/procedures. These may be placed in my permanent medical record. I agree that these images, recordings, or data may be used for education, training, or performance improvement programs as long as no information that could identify me is used.

14. MEDICAL DEVICES: I (we) accept that during the treatments/procedures, the doctor or dentist may need to place a medical device in my body. If a medical device is implanted in my body, personal information (such as my name, social security number, and medical information) will be given to the maker of the device for quality control purposes.

CONSENT:

I (we) have been given sufficient opportunity to ask questions about my condition, alternative treatments, risks of treatment, the procedures to be used, and the risks and hazards involved. All of my questions have been answered to my satisfaction, and I (we) have sufficient information to give this informed consent. I hereby consent to the above-described procedure.

I (we) certify that this form has been fully explained to me (us), and that I have read it, or have had it read to me (us), that the blank spaces have been filled in and that I (we) understand its contents.

_____ Date:_____

Signature of Patient or Legally Responsible Person Time:_____
(A.M./P.M.)

_____

Printed Name of Patient or Legally Responsible Person

_____

Signature of Witness (Include Position / Title)

_____

Printed Name of Witness

_____

To Be Completed By Physician After Patient Consent Completed:

I certify that the procedure(s) described above, including the risks, possible complications, anticipated results, alternative treatment options, including non-treatment, have been explained by me to the patient or his or her legal representative before the patient or his/her legal representative consented.

_____

Treating Physician

Date:_____

Time: _____ (A.M./P.M.)