COOPERATIVE OF
AMERICAN PHYSICIANS
333 S. Hope St., 8th Floor, Los Angeles, CA 90071
213-473-8600 800-252-7706

INSTRUCTIONS FOR USE OF CONSENT TO HYSTERECTOMY FORM

This Hysterectomy Consent form was developed in response to requests by Cooperative of American Physicians, Inc. (CAP) member gynecologists for a form which complies with the state-mandated hysterectomy consent law. This form was designed to comply with the state law and acts as an aid in focusing the discussion between you and your patient regarding the proposed hysterectomy. As this form has been written with the physician's perspective in mind (as opposed to those forms prepared by non-physician organizations) we recommend that you use the CAP Hysterectomy Consent form. Neither this consent form, nor any other, should be viewed as a substitute for your personal sharing of information in discussions with your patient regarding the proposed hysterectomy.

If you use this consent form, the following guidelines are suggested:

- Complete the consent form by making an entry in each blank section within the form.
- **Present this form to the patient yourself – its completion and presentation should not be delegated to your nurse or office staff.**
- Under state law, the patient is to receive the information outlined in the consent form both VERBALLY and IN WRITING.
- Be sure to fill in the probable anesthetic the patient will receive **and remind** the patient to discuss the risks, benefits and alternatives related to their anesthetic with the anesthesiologist or the certified registered nurse anesthetist.
- A state-mandated sterilization form must also be presented and completed by appropriate patients.
- Remind the patient to read the "Message to Patients About Medical/Surgical Risks" printed on the back of the form.
- Have the patient sign and date the consent form.
- File the original completed, signed and dated form in the patient's medical record, and give the yellow copy to the patient, along with a copy of the state-mandated sterilization form.
- You may wish to forward a photocopy of the completed consent form to the hospital for incorporation into its medical record.
- Enter a brief note in the patient's medical record stating that the risks, benefits, alternatives, and the consequences of not having the procedure were discussed with the patient and that the patient's questions regarding the proposed hysterectomy were answered. Reference should be made that the patient received copies of the Hysterectomy Consent form and state-mandated sterilization form.
- If the patient speaks a language other than English, the physician, the physician's staff, or an adult friend or relative of the patient may translate the form for the patient. The translator should sign and date the form where indicated.

Please feel free to contact the Risk Management Department if you have any questions or comments concerning the enclosed form. Our toll-free telephone number is 800-252-7706.
Additional forms are available to CAP members at no charge by faxing the order form below.

ORDER FORM FOR CONSENT - HYSTERECTOMY

Forms are free of charge to CAP members and are shipped **50 forms to a pack**.
Place an "**X**" before the number of packs you wish to order.

FAX this completed order form to: 213-473-8773

Number of Packs: ❑1 ❑2 ❑5 ❑10 ❑20

PRINT Physician Name _____ Membership # _____
Street Address (no delivery to P.O. Boxes) _____
Attention of: _____ Phone # _____
E-mail address for order confirmation _____ or Fax # _____
Name of Group (if applicable) _____

8/07

Allow 7-10 Business Days for Delivery

CONSENT TO HYSTERECTOMY

I authorize Dr. _____ and those other persons, chosen by him or her or by the hospital or medical facility, to perform an operation called a **Hysterectomy.** A hysterectomy is an operation where the uterus is surgically removed. The uterus, or womb, is the organ that holds a baby when a person is pregnant and is involved with menstruation or the monthly period. If my uterus is removed, I will never be able to have any children, and my monthly periods will stop.

MY PHYSICIAN HAS DISCUSSED THE FOLLOWING WITH ME:

⇑ **HYSTERECTOMY IRREVERSIBLE.** I am satisfied with my understanding that the hysterectomy operation is permanent and its effects can not be reversed.

⇑ **POSSIBLE BENEFITS.** I am satisfied with my understanding of the reason(s) for the hysterectomy operation. I understand my diagnosis is: _____
and that the following benefits are anticipated from the performance of the hysterectomy:

_____

⇑ **GENERAL RISKS AND COMPLICATIONS.** I am satisfied with my understanding of the more common risks and complications which are described generally on the back of this form and include infection, bleeding, pain, anesthesia risks and death.

⇑ **SPECIFIC RISKS, COMPLICATIONS AND DISCOMFORTS.** I am satisfied with my understanding of the specific risks and discomforts of the hysterectomy procedure including:

_____

⇑ **LENGTH OF HOSPITALIZATION.** My doctor has informed me that my approximate length of hospital stay is _____ days, assuming no unforeseen complications.

⇑ **LENGTH OF RECOVERY.** My doctor has informed me that my approximate length of recovery is_____ days, assuming no unforeseen complications.

⇑ **ALTERNATIVE METHODS OF TREATMENT.** I am satisfied with my understanding of alternative procedures or treatments and their possible benefits and risks including:

_____

⇑ **ANESTHESIA.** I understand that I will probably receive a _____ anesthetic. I understand the anesthesiologist or certified registered nurse anesthetist will select and administer my anesthetic. I understand I should discuss with them the risks and benefits associated with the anesthesia they select.

⇑ **NO TREATMENT.** I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

⇑ **SECOND OPINION.** I have been offered the opportunity to seek a second opinion concerning the need for my hysterectomy.

⇑ **ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT.** I understand that unforeseen conditions may arise and that it may be necessary to perform operations and procedures different from, or in addition to, the hysterectomy described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

⇑ **FEES.** My doctor has informed me that his or her fee for the hysterectomy is approximately $ _____, assuming no unforeseen complications. I understand that in addition to my doctor's fee, there will be other charges, such as hospital or facility costs, anesthesiologist's fees, laboratory and possibly other physicians' fees. I understand that not all of these charges may be paid by my insurance company and that I am responsible for paying any part of these charges not paid by my insurance company.

⇑ **FREE TO WITHHOLD OR WITHDRAW CONSENT.** I understand that I am free to withhold or withdraw my consent at any time before the hysterectomy without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded program benefits to which I might be otherwise entitled.

⇑ **NO GUARANTEES.** I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee, warrant or in any way to give an assurance of a successful result.

⇑ **OTHER QUESTIONS.** I am satisfied with my understanding of the nature of the procedure and all of my questions about the procedure have been answered.

I have read and been given a copy of this form.

DATE: _____ TIME: _____ AM/PM PHYSICIAN: _____

PATIENT NAME: _____ WITNESS:_____

SIGNATURE:_____ TRANSLATED BY (IF APPLICABLE):_____
(PATIENT)

PLEASE READ THE GENERAL INFORMATION ON BACK.

WHITE – Office Copy CANARY – Patient Copy

A MESSAGE TO PATIENTS ABOUT MEDICAL/SURGICAL RISKS

Medicine and surgery are generally safe, helpful and often lifesaving. However, medical or surgical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning. The following may be the reactions of your body to medical/surgical operations or procedures:

1. **INFECTION:** Invasion of tissue by bacteria or other germs occurs to some degree whenever a cut, incision or puncture is made. In most instances, through the natural defense mechanisms of the body, healing of the affected area occurs without difficulty. In some instances antibiotic medicines are prescribed and at times additional surgical measures may be necessary to combat infection.

2. **HEMORRHAGE:** The cutting of blood vessels causes bleeding and this occurs in every surgical incision. This bleeding is usually controlled without difficulty. At times, blood transfusions are required to replace blood loss. If blood transfusions are given, there are additional risks of liver inflammation, hepatitis, and the possibility of receiving Acquired Immune Deficiency Syndrome (AIDS). There is no absolutely reliable way to predict these unwanted reactions, some of which may be quite serious and even lead to death.

3. **DRUG REACTIONS:** Unexpected allergies, lack of proper response to medications or illness caused by the prescribed drugs are possibilities. It is important for you to inform your physician and your anesthesiologist or certified registered nurse anesthetist of any problem you or your family have had with reactions to drugs and which medications you have taken in the past six months, including over-the-counter drugs, especially aspirin.

4. **ANESTHESIA REACTIONS:** There may be unusual or unexpected responses to the gases, drugs or methods used to anesthetize you which can lead to difficulties with lung, heart or nerve function. Eating or drinking before anesthesia increases the risks of vomiting which may cause significant complications. Inform your anesthesiologist or certified registered nurse anesthetist of problems you and your family have had with anesthesia.

5. **BLOOD VESSEL INFLAMMATION AND CLOTTING:** It is impossible to predict the occurrence of blood vessel inflammation and clotting problems. If blood clots form, they can move from where they formed to other areas of the body and cause injury.

6. **INJURY TO OTHER ORGANS:** Because of the closeness of other organs to the area being operated on, there may be injury to other organs. The stress of surgery or the procedure may also harm other organ systems of the body.

7. **OTHER RISKS:** It is not possible to list all the possible risks and complications, and their variations, that may arise in any surgical operation or medical procedure. Each situation depends upon the purpose and nature of the operation or procedures. Your physician is willing to discuss further with you various details about other risks.

ALTERNATIVES TO TREATMENT

Although you and your doctor have decided upon this procedure, do not hesitate to discuss the reasons for the choice and the alternatives available for treatment of your condition. In addition, be sure to ask your doctor any other questions that you may have about your treatment.