

Consent for Dilatation & Evacuation ("D & E")

PLEASE
INITIAL

____ 1. I, _____, AGE: _____, hereby consent to the performance upon me of a Dilatation and Evacuation ("D & E") using intravenous analgesia ("CONSCIOUS SEDATION") and *local anesthesia* ("PARACERVICAL BLOCK") by Herbert Hodes, MD or Traci Nauser, MD.

____ 2. I further consent to the performance of any additional emergency procedures, which may be indicated because of unforeseen conditions arising during, or after, the "D & E" procedure.

____ 3. I have disclosed my *complete* medical history to the doctors; especially with regard to any **allergies** or adverse reactions to medications or anesthetics; any previous surgical procedures or pregnancy terminations; as well as telling them of **ANY medications** that I have taken since my last menstrual period.

____ 4. My last menstrual period began on: ____/____/____; and, IT **WAS / Was Not** **NORMAL.**
(CIRCLE ONE)

____ 5. I understand that there are very few complications from a "D & E." **ANY** surgical procedure involves risk of **possible** complications (up to death) that could occur without any fault of either doctor.

____ 6. **SOME** of the possible complications of a "D & E" are as follows:

- | | |
|--|--------------|
| a. Retained blood clots and/or tissue requiring re-suction, or D & C. | < 1: 100 |
| b. Hemorrhage (Excessive bleeding), or Infection. | < 1: 1000 |
| c. Failure of the blood-clotting mechanism (DISSEMINATED INTRAVASCULAR COAGULOPATHY, "D.I.C.")
with need for extensive blood replacement. | < 1: 1000 |
| d. Uterine Perforation with damage to other organs (bladder, intestines)
Hospitalization, Major Surgery, Hysterectomy, Sterility. | < 1: 10,000 |
| e. Death | < 1: 250,000 |

____ 7. I realize that such complications can be caused by my own medical condition **or** my conduct; by the treatment of follow-up physicians; **or** may occur spontaneously, **WITHOUT** the fault of any person.

____ - 8. If there are **any** problems after surgery, I agree to notify the doctor as explained in the *Aftercare Instructions*. I understand that failure to **promptly** notify the doctors may lead to **delay** of proper treatment, and could cause further complications. I understand that if I seek alternate treatment **WITHOUT** prior instruction of Dr. Hodes or Dr. Nauser to do so, I may **NOT** hold the doctors responsible for subsequent medical expenses, **or** any loss experienced as a result thereof.

____ 9. I agree to undergo a post-operative exam in **ONE (1) TO THREE (3) WEEKS**. Failure to do so shall absolve Dr. Hodes or Dr. Nauser of **ALL** medical, legal, or financial responsibility for any surgery-related problems that might arise at a later date.

____ 10. I acknowledge that it is **MY** responsibility to ask one of the doctors **ANY** questions that I have pertaining to the "D & E" procedure, or to this consent form **BEFORE** I sign this form below.

I certify that I have read, initialed, and FULLY UNDERSTAND this consent form.

SIGNED: _____ DATE: ____/____/____