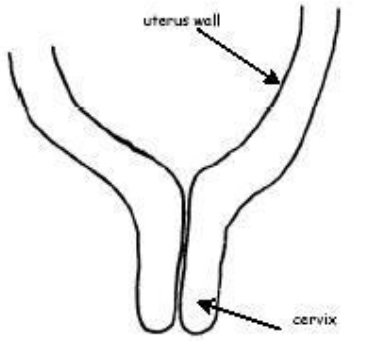
CONSENT FORM **FOR** **CONE BIOPSY**	Med Rec. No: <<Patient Demographics:Record Number>> Surname: <<Patient Demographics:Surname>> Forename:<<Patient Demographics:First Name>> DOB: <<Patient Demographics:DOB>>

This means removing a cone or cylinder-shaped piece of tissue from the centre of the cervix using a scalpel or laser beam. This is done for treatment or diagnosis.
Under a general anaesthetic, a sterile speculum is placed in the vagina. Sutures are placed on either side of the cervix, to tie off blood vessels that feed the cervix and so reduce blood loss during the procedure.
Using a special telescope (colposcope) for good vision, the cone of tissue is then cut out and sent for detailed microscopic examination. Any remaining bleeding is stopped.



RISKS
These are the more common risks. There may be other unusual risks that have not listed here. Please ask ***Dr Rana*** *if you have any general or specific concerns.*

I understand there are risks associated with any **anaesthetic,** and I can discuss these with the Anaesthetist. I may have side effects from any of the drugs used. The more common side effects include light-headedness, nausea, skin rash and constipation.

I understand a **cone biopsy** has the following **specific risks and limitations**:

- I may bleed severely during the operation, and I may require a blood transfusion.
- I may also bleed heavily a few days after the operation or after about 10 days, when the stitches used to close the blood vessels dissolve. Again transfusion, vaginal packing or reoperation may be required.
- I may develop an infection in the wound, causing an offensive discharge. This usually settles without treatment; however antibiotics and readmission may be required. Rarely the infection can spread to the uterus, tubes or abdomen.
- If I need a deep cone biopsy, my cervix may be scarred; and rarely result in cervical incompetence, increasing my risk of miscarriage and premature birth.
- I may have difficulty becoming pregnant in future, and I may have an increased risk of Caesarean section.

Electric diathermy can short circuit and cause a skin burn (<1%)

The cure rate is over 90%, thus I understand the need for follow up.

I understand some of the above **risks are more likely** if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

INDIVIDUAL RISKS:

I understand the following are possible significant **risks and complications specific to my individual circumstances,** that I have considered in deciding to have this operation:

……
……

DECLARATION BY PATIENT:

- I acknowledge that ***Dr Rana*** has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with ***Dr Rana*** any significant risks and complications **specific to my individual circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my gynaecologist during this operation.
- I consent to a **blood transfusion**, if needed.
- I agree to the disposal by the hospital authorities of any tissues or parts that may be removed during the operation. I understand that some tissues or samples may be kept as part of my hospital records.
- I have received a copy of this form to take home with me.
- If any staff member is exposed to my blood (needle stick injury) then I consent to a sample of my blood being collected for testing for infectious diseases, such as hepatitis B, C and HIV. I understand that the blood sample will not be tested until I have been informed and I have given my consent.

Signature of Patient		**Date**	

If the patient is unable to give consent, a proxy form must be completed and attached.

DECLARATION BY DOCTOR:

- I declare that I have explained the nature of the patient's condition, the procedure to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's Signature		**Date**	
Doctor's Name *(please print)*	Dr Ritu Rana		

INTERPRETER'S DECLARATION:

I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor.

Interpreter's Signature		**Date**	
Interpreter's Name *(please print)*			