LVR/COLPOPERINEOPLASTY CONSENT

Patient Name: ______________________________

Birthdate: ____/_____/____ MR #: _____________

DATE: _____/_____/_____

1. I hereby authorize __________________________________ and/or such assistants as may be selected and supervised by them to treat the following condition(s):

   Laxity of the perineum (the outer vaginal opening and outer muscles), and/or
   Laxity of the vaginal canal (the anterior and/or posterior vaginal walls), and/or
   Laxity of the levator muscles (the inner vaginal muscles, also known as Kegel muscles), and/or
   Rectocele if noted at the time of surgery (a hernia-like weakness of the posterior vaginal wall)

2. The medical/surgical treatment proposed is:

   Perineoplasty (reduction and tightening of the perineum with suturing), and/or
   Colpoperineoplasty (reduction and tightening of the inner vaginal walls with suturing), and/or
   Levatorplasty (tightening of the levator muscles (Kegel muscles) with suturing, and/or
   Rectocele repair (reinforcement of the posterior vaginal wall with suturing).
   Procedure may include laser surgery and/or radiofrequency surgery.
   Procedure may include temporary vaginal packing and/or bladder catheterization.

   (Lay terminology) *I have been told that this procedure may subject me to a variety of discomforts and risks. I understand that I will not be fully recovered from this surgery for approximately 4-6 weeks. Most patients have surgery with little difficulty, but problems can happen ranging from minor to fatal. These include nausea, vomiting, pain, bleeding, infection, poor healing, or formation of fistulas, adhesions or strictures. Urinary retention requiring catheter drainage may occur. Sexual function may improve following complete healing, but improvement cannot be guaranteed and worsened sexual function is a possibility. Unexpected reactions may occur from any drug or anesthetic given. Unintended injury may occur to other pelvic or perineal structures such as external and internal anal sphincters, and local nerves or blood vessels. Any such injury may require immediate or later additional surgery to correct the problem. Dangerous blood clots may form in the legs or lungs. Physical and sexual activity will be restricted in varying degree for an indeterminate period of time, but most often 3-6 weeks. Finally, I understand that it is impossible to list every possible undesirable effect and that the condition for which surgery is done is not always cured or significantly improved, and in rare cases may even be worse.*

3. The procedure has been explained in terms understandable to me, which explanation has included:

   a. The purpose and extent of the procedure to be performed;
   b. The risks involved in the proposed procedure, including those, which, even though unlikely to occur, involve serious consequences.
   c. The possible or likely results of the proposed procedure;
   d. The feasible alternative procedures and methods of treatment;
   e. The possible or likely results of such alternatives;
   f. The results likely if I remain untreated.

4. I am aware that there are other risks, such as loss of blood, infection or death that attend the performance of any surgical procedure. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantee or assurances have been made to me concerning the results of the proposed treatment.

5. I have had sufficient opportunity to discuss my (the patient's) condition and treatment with the doctor and/or his associates, and all of my questions have been answered to my satisfaction. I believe that I have had adequate knowledge upon which to base an informed consent to the proposed treatment.

6. I consent to the performance of additional operations and procedures different from those contemplated and deemed necessary or advisable during the course of the authorized procedure because of unforeseen conditions. The authority under this paragraph shall extend to all conditions that require treatment but were not known to the named doctor, at the time the procedure commenced.

7. I impose no specific limitations or prohibitions regarding treatment other than those that follow: (If none, so state)
   ____.

8. I consent to the administration of anesthesia and/or conscious sedation as may be deemed advisable by, or under the direction and supervision of, the physician responsible for this service. The risks, alternatives, and benefits have been discussed.

9. I consent to the retention or disposal of any tissues or parts, which may be removed.
10. I consent to the taking of photographs and videotape of the operation, procedure and/or tissue for scientific, educational and documentation purposes.
11. I understand that technical consultants may be available and present in the OR at the request of the above named physician(s).
12. I understand that medical or nursing students may be present as observers.
13. I understand that the transfusion of blood, blood bank products or autologous blood may be a necessary part of my treatment – the risks, alternatives and benefits have been explained and I therefore give consent.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTAND, AND CONSENT TO THE ABOVE PROCEDURE(S), THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. THAT ALL BLANKS AND STATEMENTS REQUIRING INSERTION OR COMPLETION WERE FILLED IN AND INAPPLICABLE PARAGRAPHS, IF ANY, WERE STRICKEN BEFORE I SIGNED. Any stricken paragraph must be initialed by both the patient and the physician.

____________________	___/___/___	_____________________	___/___/___	____________________	__/___/___
Patient Signature	Date	Witness Signature	Date	Surgeon Signature	Date