Consent For Colposcopic Examination

I, (print or type name)____________________________________________________________________
Give my consent for colposcopy, cervical biopsy, and endocervical curettage. Colposcopy is a diagnostic examination that permits a clinician to examine the cervix, vagina, and vulva with a special microscope to determine the cause of abnormal findings from an examination or Pap smear.

The colposcopic examination will assist the clinician in determining or finding an abnormal area that is visible. In order to establish the degree of abnormality and to assist in the type of treatment, one or more biopsies may of the cervix. An endocervical curettage yields a small sample of tissue removed from just inside the opening in the cervix. After analysis of tissue specimens, the laboratory provides a diagnosis for guidance in possible treatment.

I understand that a single colposcopic examination might not explain my problem, and that additional examinations and testing might be recommended.

I understand that during or after the procedure one or more of the following might occur:

• Dizziness
• Fainting
• Cramping
• Mild bleeding
• Vaginal discharge
• Infection

I have had a chance to ask questions and have had my questions answered.

______________________________________________________  __________
Patient Signature                                          Date

______________________________________________________  __________
Legal Guardian/Representative/Witness Signature           Date

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to, the proposed procedure/operation, have offered to answer any questions, and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

______________________________________________________  __________
Physician Signature                                       Date

(Rev. 1/13)