

OFFICE PROCEDURE CONSENT FORM

Procedure: Cryosurgery of Cervix

Indications: Treatment of cervical dysplasia

Alternative Treatments: Laser vaporization, LEEP, laser conization, cold knife conization, no treatment.

Risks: Bleeding, cramping, discomfort, minor or major infections, cervical stenosis, persistence of abnormal cells after treatment, subsequent inadequate colposcopy. Rarely, these could require hospitalization and/or additional surgery.

Other: _____

I have read and understand the potential risks and benefits. All of my questions regarding the procedure have been answered to my satisfaction and I desire to proceed with the procedure.

Patient Signature

Witness Signature

Print Patient Name

Physician Signature

Date