CONSENT FOR HYSTEROSCOPIC TUBAL STERILIZATION BY MICRO-INSERT
PROCEDURE EDUCATION LITERATURE

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. “An educated patient is the best patient.”*

_____I understand that the procedure involves placing a micro-insert filament into each fallopian tube that over time causes the tubes to be closed, thereby preventing pregnancy.

_____I understand that to be sure the procedure (device) has worked to close off my fallopian tubes; an HSG which is a type of x-ray with dye injected into my uterus (womb), is required approximately 3 months after the placement of the devices. If the tubes are not closed at that time, another method of birth control should be continued for an additional three months until this x-ray shows the tubes are occluded.

_____I understand that another form of birth control must be used until the HSG x-ray has confirmed that my tubes are closed.

_____I understand that some women will not have successful placement of the micro-insert devices and should consider other methods of birth control if this should happen.

_____I understand that should I become pregnant, I should immediately seek medical care for evaluation of the pregnancy, as there may be an increased risk of tubal pregnancy.

_____I understand that the procedure is considered to be a **permanent** and **irreversible** form of birth control. *If you desire future pregnancy, do not have this procedure.*

_____I understand that other risks associated with placement of the devices include, but are not limited to: bleeding, infection, uterine perforation, and pain similar to menstrual cramping.

_____I understand that this procedure does not protect against sexually transmitted diseases and that barrier methods such as condoms should be used for protection against sexually transmitted diseases.

_____I understand that if I have a nickel allergy I should not choose this form of birth control.

_____It has been explained to me that during the course of the operation or procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure or different procedures. I therefore authorize and request such surgery / procedures that are necessary in the exercise of professional judgment.

_____I have had the opportunity to ask questions regarding this and other methods of birth control and wish to proceed with the placement of the devices.

**Consent for Procedure**

I understand that during the course of the procedure unforeseen conditions might arise or be revealed that could require an extension of the procedure or performance of other operations, procedures or treatments. I therefore authorize and request the below-named individual or their designees to perform such operations, procedures or treatments that are or might become necessary in the exercise of their professional judgment.
I acknowledge that _________________ has explained the proposed procedure to me and has answered any questions that I have to my satisfaction.

I hereby consent to the above procedure. In addition, I accept all of the risks inherent to that operation and request that it be performed.

__________________________________________    Patient Name (Printed)    Patient ID    Date

__________________________________________    Physician Name (Printed)    Date

Witness    Witness Name (Printed)    Date

The information contained in this Medical Informed Consent Form ("Consent Form") is intended to solely inform and educate and should not be used as a substitute for medical evaluation, advice, diagnosis or treatment by a physician or other healthcare professional.

Please call your doctor if you have any questions.