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PATIENT INSTRUCTION SHEET AND CONSENT FOR OFFICE ENDOMETRIAL ABLATION

I, ___________________________________, hereby authorize Dr. Hanjani to perform an **Office Endometrial Ablation** procedure of my uterus to control my heavy and/or irregular menstrual bleeding. This procedure has been clearly explained to me and all of my questions have been answered. The alternatives to this procedure include: 1. no treatment, 2. hormonal therapy, 3. dilatation & curettage, 4. other types of endometrial ablation, 5. hysteroscopic rollerball ablation, 6. and hysterectomy, and have been explained to me, with their respective risks vs. benefits.

I understand that the purpose of this procedure is ultimately to remove the endometrium (lining of the uterus) to reduce or eliminate future bleeding. I understand that even though I will be premedicated with anxiolytic and non-steroidal anti-inflammatory pain medications and receive a paracervical nerve block with a local (lidocaine) anesthetic, I may still feel discomfort and/or cramping during the procedure which usually takes approximately 90 seconds to perform. I also understand that certain complications can sometimes result including but not limited to 1. When the cervix is opened tearing and bleeding can occur, which may need stitching, 2. Uterine perforation with possible injury to intraabdominal contents, 3. Infection of uterus and/or other pelvic organs, 4. Heat damage to adjoining tissues. such as vagina, bowel, or other organs, directly or from heated fluid.

I am aware that the medical literature reports that the general success rate for this procedure to control heavy bleeding is over 90% with approximately a 40% chance of amenorrhea (complete resolution of periods). I understand that ablation is not primarily intended to relieve menstrual cramps or pain.

Endometrial ablation is not a form of birth control. I am aware that I should not have this procedure done if I intend on having more children in the future. I understand that pregnancy is still a possibility after this procedure and that effective birth control continues to be important after this procedure. I understand that should pregnancy occur, there is a higher than normal chance of ectopic (tubular) pregnancy, miscarriage, and premature delivery with its sequelae.

I understand that I may have vaginal discharge for up to 2 to 3 weeks and that sexual intercourse, tub bathing, douching, and swimming should be avoided until the discharge stops. I understand that my first menstrual cycle after this procedure may be heavier than normal with the passage of tissue.

I have read the above and I fully understand the nature, purpose, risks and alternatives to **Office Endometrial Ablation,** and I am willing to undergo this procedure.

Patient: ______________________________

Physician: ____________________________ Date: ____________________
Dr Soheil Hanjani