ENDOMETRIAL BIOPSY CONSENT

I understand the following (please initial):

_____ This procedure involves the sampling of tissue from the lining of my uterus (endometrium) using a small curette and suction. The tissue sample will then be sent to a laboratory and evaluated by pathologist. Reasons for endometrial sampling include abnormal bleeding, heavy menstrual bleeding, and post-menopausal bleeding.

_____ This procedure is performed in the office without the use of anesthesia. It is possible that I may experience pelvic discomfort and cramping during and following this procedure. I may also experience nausea, weakness, and dizziness during the procedure, and if I do, the symptoms will usually disappear within 10-15 minutes.

_____ The risks involved in this procedure include, but are not limited to:

- perforation (poking through the muscle of the uterus) with possible bleeding and damage to the abdominal organs. This occurs rarely.
- infection. I should report any unusual pelvic pain, fever, or foul-smelling discharge to my provider immediately.
- bleeding or hemorrhage. I should report any heavy or prolonged bleeding to my provider immediately.

_____ If this test indicates a potential abnormality or cancer, further testing and treatment may be required.

_____ Sometimes my provider may not be able to complete the procedure due to a cervical opening that does not allow him/her to access the lining of my uterus. If this occurs, they may recommend a D&C. Also, if I have an enlarged uterus or fibroids, a sample that is complete/adequate may not be obtained, and a D&C may be recommended.

_____ I have read and understand this form and would like to proceed with an endometrial biopsy today.

_____ _____/_____/_____

Patient Name Date

_____

Patient/Health Care Agent/Guardian/Relative Signature

_____

Physician Signature