

## Endometrial Biopsy Consent

Endometrial biopsy: The removal of tissue from the lining of the uterine (endometrial) cavity.

Procedure: You will be placed in a reclining position on the examination table with your legs elevated in stirrups. A speculum will be inserted into the vagina to allow for visualization of the cervix and vagina. The cervix will be cleansed with an antiseptic solution. A small thin plastic catheter will be inserted through the cervical canal and into the uterine cavity. It may be necessary to use an instrument to open the cervix (i.e. a dilator) or one that helps with alignment in order to help pass the biopsy catheter into the uterine cavity. A biopsy of the endometrium will be aspirated into the catheter. The biopsy will be sent to a laboratory for examination by a pathologist. Results of the biopsy should be available approximately one week later.

Risks: Inclusive of but not limited to abdominal cramping, nausea, bleeding, infection, injury to the surrounding areas, uterine perforation, exposure of potential pregnancy.

Benefits: To obtain a diagnosis and/or rule out pathology.

Alternatives: Do nothing which is not recommended.

Indications: You have: 1) abnormal cells noted on cytology; 2) abnormal uterine bleeding; 3) postmenopausal bleeding; 4) abnormal thickened endometrial lining; 5) other:\_\_\_\_\_.

Post Procedure: Nothing in the vagina until your follow up visit. No sexual intercourse. No submerging in water (e.g. bathing, swimming, Jacuzzi). If you have heavy vaginal bleeding where you are changing two pads every hour for two hours or severe abdominal pain, you should go to the nearest emergency room. If you develop a fever (i.e. a temperature of 100.4 or greater), call the office.

### Acknowledgement

I acknowledge that I have read and understand this written material. I understand the risks, benefits, alternatives and indications of this procedure. I am aware that there may be other risks and complications not discussed that may occur. I also understand that during the course of the procedure, unforeseen conditions may be revealed requiring the performance of additional procedures. I also understand that technical problems with the instrumentation may prevent the completion of the procedure. I acknowledge that no guarantees or promises have been made to me concerning the results of this procedure or any treatment that may be required as a result of this procedure. This procedure has been explained to me in language that I understand. I have been given the opportunity to ask questions which have been answered to my satisfaction. I have also considered other options and alternatives. I consent to the performance of the procedure described above.

Patients Name (print) \_\_\_\_\_  
Patients Signature \_\_\_\_\_  
Physician Name (print) Honey Milestone \_\_\_\_\_  
Physician Signature  \_\_\_\_\_  
Witness Name (print) \_\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_