Vulvar/perineal/perianal Biopsy Consent

Vulvar/perineal/perianal biopsy: The removal of tissue from the external or internal female genitalia for histological examination.

Procedure: The procedure is performed in the office. You will be placed on your back in stirrups. The area that is under investigation will be cleansed with an antiseptic solution. Local anesthesia will be applied to this area. A 3/4/5 mm biopsy will be taken. A suture may be required. The biopsy will be sent to a laboratory for a examination by a pathologist. Results of the biopsy are available approximately one week later.

Risks: Are inclusive of but not limited to bleeding, infection, injury to the surrounding areas, scar tissue formation.

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

Alternatives: Do nothing which is not recommended.

Indications: You have: 1) lesion(s) with thickened skin or color changes 2) raised, hyperpigmented lesion(s); 3) lesion(s) presumed to be genital warts; 4) chronic dermatoses that unresponsive to medical therapy; 5) lesion(s) suspicious for malignancy; 6) any lesion that cannot be reliably diagnosed by visual inspection alone.

Post Procedure: Keep the area clean with soap and water. Wear a pad. Nothing in the vagina until your follow up visit. No sexual intercourse. No submerging in water (e.g. bathing, swimming, Jacuzzi). 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) _____
Physician Signature _____
Witness Name (print) _____
Date: _____/_____/_____