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100 Martin Luther king Jr Dr
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Macon
1963 Shurling Dr
Macon, GA 31211

ObGyne Consultants
formerly Bola Sogade, MD LLC

CALL US TODAY (478) 745-3014

Consent for Colposcopy

To the patient : You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Having been informed of the results of your recent pap smear, you have been advised to have a Colposcopy with possible biopsies of the cervix. This exam will allow the doctor to have a closer (magnified) view of the cervix using a binocular microscope and a speculum. (The colposcope is not inserted into the vagina). If any areas of the cervix display signs of abnormal cell changes, the healthcare provider may take a small biopsy (sample) of tissue to send to the lab for evaluation. The results of this biopsy may take approximately ten (10) to fourteen (14) working days to come back from the lab, and these results will be discussed with you at that time. (**If you do not have an appointment or hear from us after 14 days, please call to get your results).** Treatment options will be discussed based on the results of the Colposcopy exam and any biopsy that may have been taken.

RISKS OF PROCEDURE: Risks are very slight, but can include, but are not limited to, the following:

- Minor bleeding from the biopsy sites
- Infection

After the procedure, you can expect a dark discharge for a few days. This comes from the solution used to stop the bleeding. Do not put *anything* in the vagina for one week – this includes intercourse and tampons. If you experience heavy vaginal bleeding (more than one pad per hour or more bleeding than your menstrual flow), fever, chills, severe pelvic or abdominal pain, or foul smelling vaginal discharge, call the office.

_____

My signature certifies that:

- I have read and understand the contents of this form.
- Alternative treatments, if any, have been explained to me.
- I authorize _____ and whomever she/he may designate to assist him/her to perform a Colposcopy.

_____ _____

Name of healthcare provider explaining procedure Date

_____ _____ _____

Signature of Patient or Legal Representative Date DOB

_____ _____

Printed Name and Signature of Witness Date