

CONSENT FOR COLPOSCOPIC EXAMINATION

I, (print or type name) _____, give my consent for colposcopy, cervical biopsy, and endocervical curettage. Colposcopy is a diagnostic examination that permits a clinician to examine the cervix, vagina, and vulva with a special microscope to determine the cause of abnormal findings from an examination or Pap smear. The colposcopic examination will assist the clinician in determining or finding an abnormal area that is visible. In order to establish the degree of abnormality and to assist in the type of treatment, one or more biopsies may be taken. A cervical biopsy is a small sample of tissue that is obtained from the surface of the cervix. An endocervical curettage yields a small sample of tissue removed from just inside the opening in the cervix. After analysis of tissue specimens, the laboratory provides a diagnosis for guidance in possible treatment.

I understand that a single colposcopic examination might not explain my problem, and that additional examinations and testing might be recommended.

I understand that during or after the procedure one or more of the following might occur:

- Dizziness
- Fainting
- Cramping
- Mild bleeding
- Vaginal discharge
- Infection

I have had a chance to ask questions and have had my questions answered.

Date: _____ Client Signature: _____

Date: _____ Parent/Guardian Signature: _____

If translation of CONSENT FOR COLPOSCOPIC EXAMINATION was required:

- A translator was offered to the client. yes no
- The client chose to use her own translator. yes no
- This form has been orally translated to the client in the client's spoken language.
- Language translated: _____
- Translation provided by: _____
(print or type name of translator)
- Translator employed by, or relationship to client: _____
- Date: _____ Translator Signature: _____

- The client has read this form or had it read to her by a translator or other person.
- The client states that she understands this information.
- The client has indicated that she has no further questions.

Date: _____ Staff Signature: _____

Clinician Signature: _____