



Pearl W. Yee, M.D. Inc.
Obstetrics • Gynecology • Medical Aesthetics
Fertility • Menopause • Urinary Incontinence
Advanced & Minimally Invasive Female Surgery

www.pearlyeemd.com

■ 2661 Ocean Avenue, San Francisco, CA 94132
 (415) 405-0200 • (415) 405-0201 (Fax)
 ■ 1447 Powell Street, San Francisco, CA 94133
 (415) 43-DrYee (433-7933) • (415) 433-1622 (Fax)

Consent for Diagnostic Hysteroscopy, Dilation, and Curettage

I have reviewed the patient handout and information regarding hysteroscopy with dilation and curettage. I give my consent for my physician to perform a diagnostic hysteroscopy, dilation and curettage. I know that each person reacts in a different way to treatments and procedures and that results may vary. My questions have been answered about the procedure and I am aware of:

1. The treatment and procedure that my doctor plans to perform
2. What to expect from the treatment or procedures (the benefits).
3. The serious risks of this treatment or procedure that can occur despite all the steps being taken to prevent them.
4. Other types of treatment that could be used including no treatment.

Some complications include: cervical laceration, blood loss, infection, uterine perforation, damage to other organs and the need for a laparotomy. I am aware that during the procedure, other procedures might be needed. I give my consent to these procedures as needed. Additionally treatments and procedures may still be necessary following surgery.

I give my consent to receive anesthesia and/or drugs that I may need. I know that all procedures and anesthetics have a small risk of stroke, heart attack, respiratory failure and death. Other risks are tooth and nerve damage, and skin/soft tissue injury.

I give my consent for blood and/or blood products if I need them. I know that all blood and blood products can cause allergic responses, fever and hives. I know the blood bank screens donors for infections and diseases like hepatitis and HIV/AIDS, but I am aware there is a very small risk of infection. If I DO NOT WANT blood or blood products, I will fill out a separate Refusal of Blood and Blood Components.

Signature: _____ DOB: _____

Printed name: _____ Date: _____

Witness: _____