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Obstetrics, Gynecology, & Women's Health
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Disclosure & Consent for Tubal Reversal or Essure Reversal

Date: _____

Patient: _____

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.

I voluntarily request Dr. Jason W. Neef, as my physician, and such technical assistants and other health care providers as he may deem necessary, to treat my condition which has been explained to me.

DESIRE FOR PREGNANCY; PRIOR TUBAL STERILIZATION OR FALLOPIAN TUBE DAMAGE

I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures:

ROBOTIC LAPAROSCOPIC TUBAL REVERSAL AND INDICATED PROCEDURES OR CORNUAL RESECTION WITH REMOVAL OF ESSURE SYSTEM AND AMPULLARY REINSERTION

I understand that Dr. Neef may discover other or different conditions, which require additional or different procedures that those planned. I authorize Dr. Neef and such technical assistants and other health care providers to perform such other procedures, which are advisable in her professional judgement.

I understand that no warranty or guarantee has been made to me as to result or outcome; including the possibility that the reversal may be unsuccessful or that I may not be able to conceive (may not be able to become pregnant). During the process of healing, scar tissue could develop at the anastomosis site, therefore, no guarantee can be given that the tubes will remain open following the procedure.

I realize that the surgical procedures planned for me are not without risks; such as, but not limited to; infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I also realize that the following risks and hazards may occur in connection with this

particular procedure: Injury to bowel and/or intestinal obstruction, injury to tube (ureter) between the kidney and the bladder, injury to bladder, uncontrollable leakage of urine, sterility, failure to attain fertility, loss of ovarian functions or hormone production form ovaries. Injury to uterus, ovaries, fallopian tubes and/or blood vessels may also occur. Injury may require a larger incision than initially planned and/or further surgery to repair. It has been explained to me that there is the possibility that this surgery, and in particular if the reversal is associated with the removal of the Essure device, could result in the loss of uterus(hysterectomy).

I have been given an opportunity to ask questions and certify this form has been fully explained to me. I understand its contents and by signing below have no further questions.

_____ _____ _____

Patient's Signature Date Time

_____

Witness