

FINGER LAKES WOMEN'S HEALTH, LLC

OBSTETRICS AND GYNECOLOGY

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Colposcopy Consent Form

Patient name: _____

Date of Birth: _____

Today's date: _____

Chart #: _____

I hereby authorize _____ to perform a microscopic visualization of the tissue of the cervix, vagina and vulva.

The procedure consists of swabbing the area with a weak vinegar solution to remove any excess mucous and inspecting the area with a microscope. There may be one or more tiny samples of the tissue taken and sent to pathology for analysis. A scraping of the canal of the cervix may also be done and this may cause cramping. A medication may then be placed on the area to control any bleeding. If vulvar biopsies are taken, local anesthetic may be administered.

The risks of the procedure are rare, but can include bleeding, infection, injury to the tissue, and fainting.

I acknowledge that I have read and understand the consent form.

Patient Signature

Date

Witness

Cc:pt chart