MYOMECTOMY CONSENT FORM

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PATIENT'S

Patient File

No:……

Name, Surname :……

Birthdate :…….

Sex :…….

Division :……..

Consent Date :……..

Dear patient / deputy legal representative;
You have the right to be informed on the medical, surgical and diagnosis related procedures about your/your patient's health status and recommended for you/your patient, and their alternatives, benefits, risks and even possible damages that could take place, and to refuse or to accept all or part of these, or to stop the procedures to be conducted in any phase.
This form, which we ask you to read and understand, has been prepared to inform you on determining whether you will give consent for the applications or not, and to obtain your permission, and not to frighten you or scare you away from these medical applications.

INFORMATION

PREDIAGNOSIS :……

PLANNED TREATMENT / ESTIMATED DURATION:……..……

INFORMATION ABOUT THE PROCEDURE

Myomectomy can be done through vagina or abdominal section or abdominal fenestration or with laparoscoby, taking place and size of myoma into account. After removing myoma from the uterine wall, the uterus is sutured and then uterus can heal.
Suggested surgical intervention:
Abdominal
Vaginal
Laparoscobic

ALTERNATIVE TREATMENTS

POSSIBLE COMPLICATIONS REGARDING PROCEDURE

There are some risks/ complications that this surgery has. Risks associated with surgery:
If the non-treated condition persists, risks and damages may occur, and there are risks associated with surgery or medical procedures that are planned for me. I am aware of the fact that infection being typical to all surgical, diagnostic or medical procedure, blood clots in the veins and lungs, bleeding, allergic reactions, heart attack, atelectasis and even death may occur. I have been told in detail about the following risks regarding the intervention to be performed.
Some of these this risks are very rare. Risks of cesarean are higher than common for patients who: had surgery before (myoma removal, cesarean section, surgeries to treat uterine anormalities) or
with a disease (heart disease, diabetes, high blood pressure, kidney disease, who had kidney or liver transplant, coagulopathy and vascular disease), eclampsia-preeclampsia, placentaprevia, placenta acreata, increata, ablatio placent and who smoke.
Apart from the above mentioned risks, risks specific to uterine fibroid surgery can be listed as follows:
- Nausea and vomiting, pain and inflammation with fever may develop in operative section field, inside abdomen, in urinary tract.
Bladder injury
- Ureter injury risk
- Large and small intestine injury, colostomy
-Ligation of arteria interna iliaca due to postoperative bleeding that cannot be stopped or hematoma
-Bleeding and injury in the large veins in the abdomen
-Postoeprative emergence or development of urinary incontinence
-Abdominal pain and intestinal obstruction due to adhesions developing after surgery
-The uterus may need to be removed as a result of bleeding that occurred during myoma removal and cannot be stopped.
- After removal, myoma may reoccur in the same or other parts of the uterus.
-Uterine adhesions may develop due to endometrium injury and this may lead to menstruation disorders and/or infertility, recurring pregnancy loss.
Because of the above mentioned complications, the patient may need to be re-operated. Complications such as scar-celody, hernia in abdominal wall may occur.

INFORMATION ABOUT THE SUCCESS RATE

INFORMATION ABOUT THE POSSIBLE CONSEQUENCES IN CASE OF REFUSAL OF PROCEDURE

(IF MEDICINE USE IS PLANNED) INFORMATION ABOUT OF SPECIFIC MEDICINE AND ITS FEATURES

IMPORTANT LIFESTYLE SUGGESTIONS FOR PATIENT'S HEALTH

ACCESS TO MEDICAL ASSISTANCE ON THE SAME SUBJECT WHEN NECESSARY

According to health legislation, every individual has the freedom to choose hospital and physician. You can reach medical assistance in public or private health organizations about your disease within the scope of your Social Security. When necessary, you can contact our hospital 24 hours a day, or you can get medical assistance by contacting the doctor or another specialist who performed the surgery with the phone number **0090 (222) 335 0 335**. In case of emergency, you are be able to get medical assistance at a health care facility near you or via an emergency call center (112).

PATIENT'S QUESTIONS (IF ANY)

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CONSENT

I have been told all the results I might have had if I am not treated or if I refused the treatment, and, in respect of all the procedures to be performed while diagnosis and treatment, I have been explained plainly and explicitly that I may encounter with infection, blood coagulation in veins and lungs, bleeding, allergic reaction or oedema at or far from surgical area, epileptic seizure, temporary or

permanent organ/system functioning failure, death, including anameia and meningitis.

We know the other risks may be side effects, such as hypokinesis in section area, permanent scar, body deformation as a result of bone subtraction/addition, cerebral fluid leakage from surgical area or needle site, headache or longterm/chronic ache, temporary or permanent voice loss causing from vocal cord palsy, temporary or permanent function loss in organs such as face, brow, tooth, eye or hearing impairment, swallowing impairment and vision loss and loss of bladder and stool control, changes in personality, become disabled due to tissue or organ damage and occurrence of need to use medicine/hormones for a lifetime, short or longterm ache due to position during the operation, and narcotism; and hereby approve these mentioned risks.

I have read the above given information and have been informed by the undersigned doctor. I have been informed about the purpose, risks and complications of the medical or surgical intervention to be performed. I approve this process consciously, without further explanation and under no pressure I hereby authorize the person named …… with giving approval and being informed about my treatment if I lose my consciousness by some means or another and am not able to give approval during the operations related to my treatment.

…….(Please write “I acknowledge that I have read and understood above” in your handwriting)

PATIENT

Time: Signature: Date:……

Name Surname (handwriting):……..

Patient’s father/mother/legal representative* Signature:

Date / Time:

Name Surname (handwriting):……..

*The person whose name is mentioned in the last paragraph should sign.

I have made adequate and satisfactory explanation to aforementioned patient / patient relative about the disease, operation to be performed, the reason and benefits of the operation, necessary postoperative care and probable risks, type of anaesthesia to be applied, if necessary, and risks and complications regarding anaesthesia.

The patient / patient relative has signed and approved this form with their own consent that they have been adequately informed on the operation.

DOCTOR

Date / Time: Signature:

Name Surname:…….

IF THE PATIENT HAS SPEECH / LANGUAGE DIFFICULTIES:

I have interpreted the statements made by the doctor to the patient. In my opinion, the information I have interpreted is understood by the patient.

INTERPRETER'S:

Date / Time: Signature:

Name Surname (handwriting):…….

You can consult with Patient Services Directorate during the day and the Night Chief during the nights for all your complaints or any other issues you wish to address about medical applications.

*Legal Representative: The guardian for those under guardianship, the parents for minors, in cases where they do not have one of these, first degree lawful heirs. Signing this consent form does not abolish the patient's legal rights.