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Endometrial Biopsy Consent

1. I hereby authorize Dr. _____ to perform the procedure known as endometrial biopsy.
2. I understand that this is a procedure to evaluate the tissue (endometrium) lining the inside of my uterus (womb.) The procedure is usually performed to evaluate abnormal or excessive vaginal bleeding, lack of vaginal bleeding, or to exclude the presence of cancer. A thin plastic catheter will be inserted into my uterus and moved back and forth as suction is applied to obtain a tissue sample. The doctor may need to dilate the opening to my uterus to pass the catheter into my uterus. The entire procedure can be somewhat uncomfortable, and efforts will be made to minimize my discomfort. I understand that the practice of medicine is not an exact science and that no guarantee can be made regarding the outcome of my planned procedure.
3. My doctor has explained to me that the procedure is generally safe, but that certain risks accompany any procedure. Risks associated with endometrial biopsy include:
 - Bleeding, sometimes lasting for several days after the procedure.
 - Damage to an unknown pregnancy that is present when the biopsy is performed.
 - Pain and cramping.
 - Perforation (a hole in the uterus wall) that may require surgical closure.
 - Allergic reaction to medications or instruments used.
 - Infection in the uterus or nearby tissues.
 - Rare, unusual reactions, including possible death following any surgical procedure.
4. I understand that there are alternatives to this procedure, such as visualizing the uterine lining with hysteroscopy, ultrasonography, or CT scan. I understand that the alternative procedures are more expensive and may not provide information beyond what the endometrial biopsy can provide.
5. I understand that I can refuse the procedure.
6. I understand that unforeseen conditions may alter the planned procedure. I give permission to my doctor to alter the procedure (such as to mechanically dilate a closed cervical canal) if necessary, or to administer additional anesthetics or medications if I should need them for the completion of my procedure.
7. I have read this form and any other sheets given to me by my doctor. I have had my questions answered to my satisfaction.

I, _____, consent to receiving an endometrial biopsy.
(Patient Name)

Patient Signature or Patient Representative Signature

Date

Minor

Parent

Witness

Date