DILATION AND CURETTAGE (D&C)

A dilation and curettage (D&C) is the dilatation of the cervix and the curettage (scraping away) of the lining of the uterus. The vaginal canal is held open by a speculum, and the opening to the uterus (cervix) may be anesthetized. The cervical canal is widened (dilated) and a curette (a metal loop on the end of a long, thin handle) is then passed through the canal into the uterine cavity. The inner layer of the uterus (endometrium) is scraped away.

Patient’s
Initials

The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

I understand and accept that the most likely material risks and complications of a dilation and curettage have been discussed with me and may include but are not limited to:

- heavy vaginal bleeding or passage of clots
- infection; and/or infection of the uterus, fallopian tubes, or ovaries
- infertility
- laceration of or damage to the cervix
- perforation of the uterus
- reactions to medicines
- scarring of the uterine lining
- tearing of the uterine wall
- infertility
- tearing of the uterine wall

I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.

I am aware that smoking during the pre- and postoperative periods could increase chances of complications.

I have informed the doctor of all my known allergies.

I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

I have been advised whether I should take any or all of these medications on the days surrounding the procedure.

I am aware and accept that no guarantees about the results of the procedure have been made.

I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____________________, M.D., with associates or assistants of his or her choice, to perform a dilation and curettage on _____________________ at_________________________.

(patient name)

(name of facility)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time  _____________________

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

continued
I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications and alternatives to the proposed treatment and the risks and consequences of not proceeding, have offered to answer any questions, and have fully answered all such questions. I believe that the patient/legal representative (circle one) fully understands what I have explained.

________________________________________
Physician Signature/Date/Time

_______ copy given to patient  _______ original placed in chart
initial  initial