

PAP SMEAR

The Pap smear is a cancer screening test that has reduced the death rate from cancer of the cervix by 70% in the last 50 years. Cells are collected from your cervix (a part of the uterus, or womb) and smeared on a glass slide. A trained technician examines these cells through a microscope looking for cancer cells, or cells that could become cancerous.

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 am aware that the Pap smear test detects malignant or abnormal cells 75–85% of the time and fails to detect them 20–25% of the time.
- _____ I am aware that sometimes abnormal cells that may be present on the cervix are not collected or are not transferred to the glass slide.
- _____ I am aware that sometimes abnormal cells are present on the glass slide but are missed or not recognized in the laboratory.
- _____ I am aware that I should receive a Pap smear test **every** year.
- _____ I am aware that the technician examining the slide must look at more than 100,000 cells. Often only a few of these are abnormal.
- _____ I am aware that even under the best circumstances at least 15 out of 100 *abnormal* Pap smears may be read as normal.
- _____ I am aware that occasionally, cells that are actually *normal* are misidentified as abnormal.
- _____ I am aware that I should report to my physician any abnormal signs such as: excessive discharge, bleeding that is heavier than usual for my menstrual period, or bleeding that occurs after sex. A normal Pap smear test does not mean that I can ignore these symptoms.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ The doctor has answered all of my questions regarding this procedure.

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 Pap smear 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

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

initial

initial

SAMPLE