TUBAL LIGATION

Tubal ligation is a surgical procedure that permanently closes the fallopian tubes, which causes permanent sterility by preventing transport of the egg (ovum) to the uterus, and by blocking the passage of sperm up the tube to the ovulating ovary where fertilization normally occurs. A tubal ligation may be done in the following ways: laparoscopy, open tubal ligation (laparotomy), minilaparotomy (“mini-lap”), postpartum tubal ligation.

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 tubal ligation have been discussed with me and may include but are not limited to:

- bleeding
- ectopic (or tubal) pregnancy
- injury to adjacent organs or structures
- infection
- incomplete closure of the tubes and possible fertility
- pain or discomfort

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

______ I understand and accept the risks of blood transfusion(s) that may be necessary.

______ I understand that tissue cannot heal without scarring and that how one scars is dependent on individual genetic characteristics. The physician will do his/her best to minimize scarring but cannot control its ultimate appearance.

______ I understand that tubal sterilization is a permanent method of birth control.

______ 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 advised of the probable consequences of declining recommended or alternative therapies.

______ 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.

______ 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 tubal ligation 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

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