



## SURGICAL INFORMED CONSENT

**Patient Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **MR#** \_\_\_\_\_

**PRE-OP NOTE:** The surgical Risks/Benefits/Options were discussed fully.

**SURGERY:** I request the following surgery/surgeries to be performed by Dr. Alinsod and his assistants:  
(Please initial surgeries to requested or recommended)

**GYNECOLOGIC SURGERY:**

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| <input type="checkbox"/> Suburethral Sling, Cystoscopy<br><input type="checkbox"/> Anterior Repair, Paravaginal Repair<br><input type="checkbox"/> Posterior Compartment Repair<br><input type="checkbox"/> Enterocele Repair<br><input type="checkbox"/> Vaginal Vault Suspension<br><input type="checkbox"/> SSLS<br><input type="checkbox"/> PIVS<br><br><input type="checkbox"/> TVH, Total Vaginal Hysterectomy<br><input type="checkbox"/> TAH, Total Abdominal Hysterectomy<br><input type="checkbox"/> LSH, Laparoscopic Supracervical Hys.<br><input type="checkbox"/> LAVH, Laparoscopically Assisted Vaginal Hysterectomy<br><input type="checkbox"/> LH, Laparoscopic Hysterectomy<br><br><input type="checkbox"/> Hysteroscopy<br><input type="checkbox"/> Endometrial Resection<br><input type="checkbox"/> Endometrial Ablation/HTA<br><input type="checkbox"/> Polypectomy<br><input type="checkbox"/> Myomectomy<br><input type="checkbox"/> Septoplasty<br><input type="checkbox"/> Dilatation and Curretage<br><input type="checkbox"/> Cystoscopy with Bladder Botox | <input type="checkbox"/> Laparoscopy<br><input type="checkbox"/> Lysis of Adhesions<br><input type="checkbox"/> Fulguration of lesions<br><input type="checkbox"/> Cystectomy<br><input type="checkbox"/> LUNA<br><input type="checkbox"/> Ureteral Dissection<br><input type="checkbox"/> Laparotomy<br><br><input type="checkbox"/> Bilateral Salpingo-oophorectomy<br><input type="checkbox"/> Unilateral Salpingo-oophorectomy<br><input type="checkbox"/> Ovarian Cystectomy<br><br><input type="checkbox"/> Other _____<br>_____<br>_____<br>_____ |
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**AESTHETIC VAGINAL SURGERY**

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|--|---|
| <input type="checkbox"/> Labia Minora Plasty<br><input type="checkbox"/> Barbie Doll Appearance<br><input type="checkbox"/> Rim Appearance<br><input type="checkbox"/> No preference<br><input type="checkbox"/> Labia Majora Plasty<br><input type="checkbox"/> Clitoral Hood Reduction<br><input type="checkbox"/> Vaginoplasty<br><input type="checkbox"/> Tightness to approximately "one finger"<br><input type="checkbox"/> Tightness to approximately "two fingers"<br><input type="checkbox"/> Tightness to approximately "three fingers"<br><input type="checkbox"/> Perineoplasty<br><input type="checkbox"/> Hemorrhoidectomy<br><input type="checkbox"/> Skin Resurfacing<br><input type="checkbox"/> Hymenoplasty | <input type="checkbox"/> Other _____<br>_____<br>_____<br>_____ |
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**DISCLOSURE:** Dr. Alinsod and his staff have given me full disclosure regarding my surgery. I have read the handouts on the above aesthetic vaginal surgeries. I have also read the Post-Op Instructions and viewed Post-Op Videos. I understand what I am having done and the extent of surgery provided.

**QUESTIONS:** I have had a chance to ask all the questions I have requested and have been satisfied with the answers given. I am free to ask questions at any time. I have no further questions at this time.

**BENEFITS:** The benefits have been fully disclosed and I completely understand them. They include improved comfort, a more pleasing appearance, confidence in personal appearance, possibly less pain and discomfort. Pelvic surgery may also relieve abnormal bleeding, pressure, and other symptoms.

**RISKS:** The risks have been fully disclosed and I completely understand and accept these risks including but not limited to the following:

\_\_\_\_ **Risks Specific to Gynecologic Surgery: Please initial**

- Anesthesia (aspiration, high temperature, incomplete anesthesia, rash, anaphylaxis, unknown reaction to anesthetics, difficulty breathing)
  - I have chosen my anesthesia to be:
    - \_\_\_\_ Topical/Local with mild sedation by injections
    - \_\_\_\_ Spinal or epidural
    - \_\_\_\_ General Anesthesia
  - I have chosen my location of surgery to be:
    - \_\_\_\_ SCU Office Procedure Room
    - \_\_\_\_ Hospital
    - \_\_\_\_ Surgery Center
- Infection (need for wound cleaning, wound drainage, antibiotics)
- Bruising, Bleeding/Hemorrhage from vessel damage or clotting problems and the possibility of needing transfusion of blood products or fluid expanders
  - Risks of transfusion related anaphylaxis, Hepatitis, HIV, other unknown organisms
- Blood clots in the pelvis, lungs, or brain with a need for blood thinners or surgery
- Hematoma formation with need for evacuation of large or growing hematomas and the possibility of needing drains
- Damage to internal organs (i.e. bowel, bladder, ureters, urethra) with need for repair or revision
- Hernia formation from surgical sites or recurrence of lesions
- Nerve damage (i.e. loss of sensation, hypersensitivity and irritation, pain, loss of muscle control)
- Suture breakdown and/or rapid suture autolysis and possible need for placement of new or different sutures
- Prolonged catheterization or difficulty in emptying bladder may occur, an indwelling catheter may be used, and the possibility of urinary retention was also discussed and accepted.
- Incontinence may occur or get worse from pelvic prolapse repairs.
- I understands further procedures or surgeries may be needed in the future for revision/repair/removal. No guarantees are implied or given to the patient regarding the safety and efficacy of the procedure.

The possibility of infection/rejection/erosion/pain due to mesh or tissue were discussed if they are used. The type of implant (if needed) was discussed fully with the patient and she has agreed to its use in repairs. I understands that pain/dysparunia may occur with and without the use of mesh or tissue.

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\_\_\_\_ **Risks Specific to Aesthetic Vaginal Surgery: Please initial**

- Improper or unappealing healing with wound edges not perfectly aligned including asymmetric healing where one side may be more or less prominent than the other side
  - I understand that every individual heals differently
  - I understand that retraction of edges may occur and that even a Rim appearance Post-Op may retract into a Barbie Doll appearance later on
  - I understand that variable blood supply may hamper proper healing

- I understand that activities I perform may damage my surgical repair and that strict adherence to my post-op instruction is critical
- I understand that I am not allowed to have sexual relations until cleared by Dr. Alinsod
- I understand that scarring from reaction to sutures, infections, keloids may occur and that all scars may not be hidden from view or may actually be more prominent depending on the healing process
- Need for wound revision(s) or resurfacing procedures may be needed to achieve the desired look and appearance
  - I understand that revisions are performed by Dr. Alinsod free of charge within one year of original surgery
  - I understand that consultations and revisions performed by other surgeons are my financial responsibility
  - I understand that revisions may not be able to accomplish the cosmetic goals I am seeking
- I understand that Dr. Alinsod does not guarantee that he will be able to achieve the results I am seeking. No guarantees have been implied or given.
- I fully understand the ramifications of a vaginoplasty that is tight (i.e. painful intercourse, scars and bands inside the vagina, and the need for revision) and that diligent vaginal softening exercises will be needed to be performed from two weeks to a month or more starting at about the sixth week Post-Op depending on the size desired.
- I fully understand that hymenoplasty may result in painful intercourse initially with the possibility of bleeding and hemorrhage. It is also possible that I may not bleed. I also understand that the hymen may need to be incised to release retained fluids or for comfortable intercourse.

**\_\_\_\_OPTIONS: Please initial**

Since this is elective surgery I have had the chance to research other surgeons and surgical approaches. The options of care have been fully discussed such as outside consultations and surgery, no surgery, expectant management (wait and see), medical management, or to proceed with the agreed upon surgery. I have chosen to proceed with the elective surgery willingly and without hesitation at the time frame of my choosing.

**OTHER CONCERNS AND DISCUSSIONS:**

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**PATIENT SIGNATURE**

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**PHYSICIAN SIGNATURE**

**Red M. Alinsod, M.D., FACOG, FACS, ACGE**

**WITNESS SIGNATURE**

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**DATE**

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**REVIEWED**

**NO CHANGES**

**DATE**

**CHANGES**

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