Roy M. Brooks, MD
Asha Barrett, MD
Andrew B. Block, MD
Eric Ashkin, MD
Julie G. Glass, MD
Ronald D. Jacobs, MD
Gayle F. Friedman, MD
Lauren F. Ng, MD
Anne Seifert, CNM.
Meredith Tussing, WHNP

CAPITAL WOMEN'S CARE
Working Together for Women's Health

TO: All Patients Scheduled for a Hysterectomy

FROM: Capital Women's Care

RE: Hysterectomy Consent Form

My signature on this form acknowledges the fact that I have consented to have Dr. _____ perform a hysterectomy on me. My signature on this form also acknowledges the fact that I have received and read the pamphlet entitled "Understanding Hysterectomy" published by the American College of Obstetricians and Gynecologists. I understand and have discussed all risks and benefits regarding this surgery with my physician. I have been informed of alternative surgical and / or medical treatments if applicable. I understand, as with any major abdominal or pelvic operation serious complications such as blood clots, severe infection, postoperative (after surgery) hemorrhage, bowel obstruction, injury to the urinary tract, or even death can occur. All questions regarding this procedure have been discussed and answered to my satisfaction.

_____
Signature

_____
Print Name

_____
Address

_____

_____
Date

7350 Van Dusen Road
Suite #330
Laurel, Maryland 20707
(301) 468-0073

2101 Medical Park Drive
Suite #200E
Silver Spring, Maryland 20902
(301) 468-0073

121 Congressional Lane
Suite #100
Rockville, Maryland 20852
(301) 468-0073