BOSTON MEDICAL CENTER

Consent to Special Procedure

I, _____, hereby authorize the physician, dentist or surgeon in charge, together with such assistants as he may designate, to perform the following special procedure.

Endometrial Biopsy (NAME OF PROCEDURE) , Sampling of the lining of the uterus (BRIEF DESCRIPTION/EXPLANATION)

Risks include bleeding, infection, and injury to internal organs

and such additional operations or procedures as are considered necessary on the basis of findings during the course of said special procedure. Any tissues or parts surgically removed may be disposed of by Boston Medical Center in accordance with accustomed practice.

The nature, extent, and purpose of the operation, possible alternative methods or treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee has been made as to the results that may be obtained.

I certify that I have read and fully understand the above consent, that explanations have been made, and that the physician, dentist or surgeon has answered all of my questions.

DATE

PATIENT
AND/OR

WITNESS (PHYSICIAN)

RESPONSIBLE RELATIVE or GUARDIAN

RELATIONSHIP