One Boston Medical Center
Place Boston, MA 02118

Consent to Special Procedure

I, _____, hereby authorize my physician or surgeon in charge, _____
MD NAME
together with such assistants as he/she may designate, to perform the following special procedure:

IUD Insertion Mirena Para Gard
(NAME OF PROCEDURE) (CROSS OUT IF NOT APPLICABLE)

Placement of birth control in your uterus
(BRIEF DESCRIPTION/EXPLANATION IN LAY TERMS)

RISKS INCLUDE: The following represent some, but not all the potential risks associated with the recommended procedure(s): Cramping, pain, bleeding, infection, allergic reaction to medication, failure of device (pregnancy and ectopic), expulsion, perforation.

Additional operations or procedure 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 understand that a blood transfusion may be necessary, and I hereby consent to the transfusion of blood/blood products. I have received an explanation of risks, benefits and alternatives to a transfusion. (Cross out if not applicable.)

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 Time Patient and / or

_____ _____
(Physician Signature) Responsible Relative or Guardian

_____ _____
Print Name Relationship to Patient