SOUTH MIAMI OB-GYN ASSOCIATES

Procedure: **Bilateral Salpingectomy**

Purpose of Procedure:

To perform a permanent sterilization on me by either removing a portion of my tubes, burning a portion of my tubes, or putting a clip/ring on my tubes.

I understand that this procedure must be considered permanent and not reversible (I will not be able to have a child after it).

Alternatives:

Not to have this procedure and use another method of contraception such as the pill, condoms, diaphragm, hormone injections, IUD etc.

Have my partner undergo a vasectomy (male permanent sterilization)

Risks of the Procedure:

In general, this procedure is extremely safe, but occasionally the following complications may occur:

Bleeding: sometimes requiring other surgeries to stop it. Rarely a transfusion may be required and I accept the risks of such a transfusion

Infection: sometimes requiring antibiotics, and in rare cases admission to the hospital and/or additional surgery

Injury to other organs: rarely the intestine, bladder, a blood vessel or other tissues may be accidentally injured and additional surgery may be required to repair them

Scar tissue: my internal organs and my skin can form scar tissue, which can lead to pain or other problems

Reaction to the anesthesia: or other relatively less common problems that can pose serious consequences to my health

Chances of Success:

About one in 200 times this procedure can fail and I may still become pregnant. I will not hold the doctor liable for this failure since it is a known accidental occurrence after having this procedure performed.

Financial Responsibility:

I understand that I am financially responsible to the doctors for this procedure. I understand that the office as a courtesy will file to my insurance carrier for this surgical procedure however I am responsible for any non-covered, non-allowed portion. I consent to the release of my medical records regarding this procedure to my insurance carrier including this consent.

I have read and fully understand the above and voluntarily consent to have this procedure performed on me. This physician has answered all my questions.

Patient Name_____ **Signature**_____

Witness _____ **Date** _____

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