Center For
WOMEN'S HEALTH
& WELLNESS

Patricia Ristic, M.D., F.A.C.O.G.
Susan Fox, D.O., F.A.C.O.O.G.
Darren Salinger, M.D., F.A.C.O.G.
Tiffany Leon, MSN, APRN, FNP-BC
Diana Zambrana, MSN, APRN, FNP-BC
Nelly Maurant Grass, MSN, APRN, FNP-BC

Informed Consent

Tissue Sampling for Laboratory Evaluation

My Physician, _____ has recommended me to have the diagnostic procedure below, because he/she has determined my history and/or symptoms indicates that I am in a high risk category, for which the latest medical information recommends the following diagnostic procedure.

The benefits and risks of checked procedure have been explained and I fully understand the explanation. I also understand this procedure is normally performed in the doctor's office with either no anesthesia or if necessary a local anesthesia.

- ⬜ Polyp Removal
- ⬜ Endocervical Tissue Biopsy
- ⬜ Skin Tag Removal
- ⬜ Colposcopy
- ⬜ I choose not to have this procedure performed
- ⬜ Hysterosonogram
- ⬜ Endometrial Tissue Biopsy
- ⬜ Breast Aspiration Needle Biopsy
- ⬜ Removal of Vaginal Warts

If I have any of the following conditions, I will notify you prior to having this procedure done as it may mean the procedure should not be done of this time.

- ⬜ Severe Anemia
- ⬜ Heart Disease
- ⬜ Extreme Anxiety
- ⬜ Clotting Mechanism Deficiency
- ⬜ Pelvic Infection
- ⬜ Other Health Conditions of which you may have

I understand that no warranty or guarantee has been made as to the results of this procedure. I have read the above information and understand fully the contents of each paragraph.

I understand that students and representative for the device in the medical field will be present at the time of the procedure.

Patient Name: _____ Date Of Birth: _____/_____/_____

Patient Signature: _____ Witness: _____

Today's Date: _____/_____/_____

8501 SW 124th Ave #211
Miami, FL 33183

Office Phone: (305) 595-6488
Fax: (305) 595-3532