Gina S. Nelson, M.D., P.C.,
210 Sunnyview Lane, Suite 104
Kalispell, MT 59901

Informed Consent -
ENDOMETRIAL TISSUE SAMPLING BY PIPELLE

I hereby direct and request, Gina S. Nelson, M.D., my physician, to perform an endometrial tissue sampling in her office. I understand that this procedure involves the removal of tissue from the lining of my uterus using a small pipelle instrument. The tissue sample will then be evaluated by the laboratory. I further understand that you will normally perform this procedure in your office with a local anesthesia. I have been informed of the benefits and risks involved in this procedure, including but not limited to:

1) If I am pregnant, this procedure should terminate my pregnancy. However, it is within the realm of possibility that this procedure will not terminate my pregnancy. If any existing pregnancy is not terminated, I may have to decide whether I wish to have a repeat procedure performed at a later time.

2) Perforation of the uterus with possible damage to abdominal organs is possible, but occurs in very few cases.

3) There is a risk of infection or hemorrhage. I understand that I should report back to my physician immediately any unusual bleeding or fever.

4) If this test indicates a potential abnormality or cancer, further testing and treatment may be required.

5) The diagnostic accuracy of this procedure compares favorably with that of an in-hospital D&C.

6) If I should have an enlarged uterus or fibroids, a complete sample may not be obtained by this technique.

7) It is possible that I may experience pelvic discomfort and cramping during and following the procedure.

8) I may experience nausea, weakness or dizziness during the procedure, but If I do, they will usually disappear within 10 to 15 minutes. I should be able to leave the office on my own after this procedure.

9) If I have any of the following conditions, I should notify you now, as it may mean that this procedure should not be performed:

____ SEVERE ANEMIA
____ HEART DISEASE
____ PELVIC DISEASE
____ CLOTTING MECHANISM DEFICIENCY
____ EXTREME ANXIETY
____ OTHER HEALTH CONDITIONS WHICH YOU, MY PHYSICIAN, SHOULD BE INFORMED

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

_____ _____
Patient's Signature Date

_____ _____
Witness Date