AIAVS
ALINSOD INSTITUTE
for AESTHETIC VULVOVAGINAL SURGERY

TODAY'S DATE: _____

PATIENT'S NAME:

_____

DOB: _____

ACCOUNT#_____

SURGICAL INFORMED CONSENT

PRE-OP NOTE: Surgical Risks/Benefits/Options have been fully discussed.

SURGERY: I request the following surgery(ies) and/or procedure(s) to be performed by Dr. _____
(**Please initial** surgery(ies) and/or procedure(s) requested or recommended, indicated by mark or highlighter)

GYNECOLOGIC SURGERY:

____□Suburethral Sling (TOT/TVT)
____□Cystoscopy
____□Anterior Repair, Paravaginal Repair ____□Mesh ____□Biologic ____□Native
____□Posterior Compartment Repair ____□Mesh ____□Biologic ____□Native
____□Enterocele Repair ____□Mesh ____□Biologic ____□Native
____□Vaginal Vault Suspension ____□Mesh ____□Biologic ____□Native
____□SSLS (Sacro-Spinous Ligament Suspension)
____□PIVS (Posterior Intra-Vaginal Slingplasty)
____□Uterine Suspension ____□BSO (Bilateral Salpingo-oophorectomy)
____□Laparotomy
____□Laparoscopy ____□USO (Unilateral Salpingo-oophorectomy)
____□Lysis of Adhesions
____□Fulguration of Lesions ____□Ovarian Cystectomy
____□Cystectomy
____□LUNA (Laparoscopic UteroSacral Nerve Ablation)
____□Urethral Dissection ____□Band Release

____□TVH (Total Vaginal Hysterectomy)
____□TAH (Total Abdominal Hysterectomy)
____□LSH (Laparoscopic Supracervical Hysterectomy)
____□LAVH (Laparoscopically Assisted Vaginal Hysterectomy)
____□LH (Laparoscopic Hysterectomy)

____□Hysteroscopy ____□Endometrial Biopsy
____□Endometrial Resection ____□Endometrial Ablation/HTA
____□Polypectomy (Hydrothermal Ablation)
____□Dilatation and Curretage ____□Myomectomy
____□Cystoscopy with Hydrodistention ____□Cystoscopy with Bladder Botox

____□Other_____
_____

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
DATE **TIME**

____□ THESE PROCEDURES DOES **NOT** APPLY TO ME.

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
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SURGICAL INFORMED CONSENT

AESTHETIC VAGINAL SURGERY

____□Labia Minora Plasty ____□Curvilinear ____□Wedge ____□ Labia Minora Revision
____□Barbie Appearance
____□Rim Appearance
____□Hybrid
____□No preference

____□Labia Majora Plasty ____□ Labia Majora Revision
____□Clitoral Hood Reduction and Contouring ____□ Clitoral Hood Reduction Revision
____□Vaginoplasty ____□ Vaginoplasty Revision
Tightness to approximately:
_____□ "**one** finger" _____□ "**two** fingers" _____□ "**three** fingers"

____□Perineorrhaphy/ Perineoplasty ____ □ Perineorrhaphy/ Perineoplasty Revision
____□External Hemorrhoidectomy/Anal Tag Removal ____ □ Hemorrhoidectomy/Anal Tag Revision

____□Skin Resurfacing AREA: _____
____□Resuturing AREA: _____

____□Hymenoplasty

____□PRP/Amniotic Fluid Injection ____□G-Spot/Clitoral/Periurethral (aka O-Shot)

____□Vampire Wing Lift of the Majora with PRP and Hyaluronic Acid

____□Radiofrequency Treatments of Vulvovaginal Areas (Internal and/or External)

____□Other_____

ADDITIONAL PROCEDURES: I understand that:
____□ NO PROCEDURES CAN BE ADDED ON THE DAY OF SURGERY**.**
____□ Additional surgery(ies) / procedure(s) must be requested NO LATER THAN **FIVE (5) DAYS** PRIOR to my scheduled surgery date.

(NOT APPLICABLE IF CONSULTATION AND SURGERY ARE SCHEDULED FOR THE SAME DAY)

I have chosen my location of surgery to be:
____□SCU Office Procedure Room
____□Surgery Center

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
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SURGICAL INFORMED CONSENT

_____ **QUESTIONS:**

- I have had a chance to ask all the questions on the surgery(ies) / procedure(s)
- I have requested and have been satisfied with the answers given.
- I understand what I am having done and the extent of the surgery(ies) / procedure(s) provided.
- I am aware that I am free to ask questions at any time. Contact information has been provided to me. I have no further questions at this time.

_____ **BENEFITS OF SURGERY**:

The benefits have been fully disclosed and I completely understand them.
They include:

- Improved comfort
- Possibly less pain and discomfort

Pelvic surgery may also relieve:

- Abnormal bleeding / Heavy Bleeding
- Pressure / Heaviness / Fullness
- Other symptoms such as urinary and bowel dysfunction

_____ **AESTHETICS:**

- Improved comfort
- A more pleasing appearance
- Confidence in personal appearance

_____ **HYSTEROSCOPY/ ENDOMETRIAL ABLATION:**

- Decreased Bleeding
- Decreased Irregular Bleeding
- Possible decrease in Uterine Discomfort
- Analyze Endocervical and Endometrial tissues

_____ **LAPAROSCOPY** (Assists in Diagnosis)**:**

- Decrease pain / discomfort
- Reduced Cyst pain / formation
- Remove / reduce adhesions or lesions

PATIENT SIGNATURE: _____ _____/_____/_____ (DATE) ____:_____ (TIME)

REVIEWED_____

TODAY'S DATE: _____
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SURGICAL INFORMED CONSENT

RISKS SPECIFIC TO GYNECOLOGIC SURGERY: Please Initial
The risks have been fully disclosed and reviewed by me and I completely understand and accept these risks including but not limited to the following:

_____ Anesthesia
- · Aspiration
- · High temperature
- · Rash
- · Difficulty breathing
- · Anaphylaxis
- · Infection
- · Incomplete anesthesia
- · Throat Discomfort
- · Unknown reaction to anesthetics

  - **I HAVE CHOSEN MY ANESTHESIA TO BE:**
    _____ Topical/Local with mild sedation by injections
    _____ Spinal or epidural
    _____ General Anesthesia

_____ Infection
- · Need for wound cleaning
- · Wound drainage
- · Antibiotics

_____ Bruising, Bleeding/Hemorrhage from vessel damage or clotting problems and the possibility of needing transfusion of blood products or fluid expanders.
  - Related risks of transfusion:
    - · Anaphylaxis
    - · Shock
    - · Hepatitis
    - · HIV
    - · Other unknown organisms

_____ Blood clots in the pelvis, lungs, or brain with a need for blood thinners or surgery.

_____ Hematoma formation with need for evacuation of large or growing hematomas and the possibility of needing drains.

-List continues on page 5

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
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SURGICAL INFORMED CONSENT

-List continued from page 4

_____ Damage to internal organs with need for repair or revision
- Bowel: perforation, blockage
- Bladder: perforation, tears, mesh erosion, suture in bladder
- Ureters: occlusion, kinking, transection
- Urethra: occlusion, kinking, perforation, deviant urine flow, urinary retention

_____ Hernia formation from surgical sites or recurrence of lesions.

_____ Nerve damage
- Loss of sensation or reduced sensation
- Hypersensitivity
- Irritation
- Pain
- Loss of muscle control

_____ Suture breakdown and/or rapid suture autolysis and possible need for placement of new or different sutures.

_____ Prolonged catheterization or difficulty in emptying bladder may occur; an indwelling catheter may be used, and the possibility of urinary retention was also discussed and accepted.

_____ Incontinence may occur or get worse from pelvic prolapse repairs.

_____ Urge symptoms to urinate may occur.

_____ I understand further procedures or surgeries may be needed in the future for
· revision · repair · removal · scar reduction · band release

_____ No guarantees have been implied and/or given to the patient regarding the safety and efficacy of the procedure nor has any guarantees been implied and/or given in regards to results.

_____ Surgery may fail and may need to be redone.

_____ Death is a possibility with any surgery.

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SURGICAL INFORMED CONSENT

____ **SURGICAL MESH or BIOLOGIC AUGMENTATION**

I understand that the use of the surgical mesh for reinforced prolapse repair may not be suitable for every patient and that the potential complications involved with mesh surgery include but are not limited to the following:

- Pelvic pain, need for band or scar release
- Pain with intercourse (Dyspareunia), need for band or scar release
- Scarring of surgical site needing band release or excision of scars
- Bleeding and/or hemorrhage, needing transfusion
- Injury to blood vessels, nerves, bladder, urethra or bowel during mesh placement, which may require surgical repair
- Narrowing and/or shortening of the vagina
- Mesh infection or non- healing
- Inflammation of surgical site
- Mesh may need to be trimmed or removed if pain occurs
- Mesh extrusion from the vagina; need for mesh/biologic trimming or excision
- Mesh erosion into adjacent organs
  - Urethra
  - Bladder
  - Rectum
- Adhesion and/or fistula formation
- Injury and/or damage of rectum, small and large bowel, needing colostomy
- Nerve damage or irritation
  - Pudendal Neuralgia
  - Overactive bladder / Urge symptoms
- Temporary or permanent difficulty with urination or defecation
- Recurrent prolapse
- Failed Repair

The risks listed above have been fully disclosed, discussed and explained to me.
No guarantees have been implied and/or given to me regarding the safety and efficacy of the procedure and the use of mesh; nor has any guarantees been implied and/or given in regards to results. I have reviewed all information and I understand and accept these risks in its entirety and I still authorize Dr. Alinsod's use of mesh in repairs.

PATIENT SIGNATURE: _____ _____/_____/_____ ____:_____
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____ THESE PROCEDURES DOES **NOT** APPLY TO ME.

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SURGICAL INFORMED CONSENT

RISKS SPECIFIC TO AESTHETIC VULVOVAGINAL SURGERY: Please initial

_____ Improper or unappealing healing with wound edges not perfectly aligned, scalloping of edges, including asymmetric healing where one side may be more or less prominent than the other side

_____ I understand that every individual heals differently

_____ I understand that retraction of edges may occur and that even a Rim appearance Post-Op may retract into a Barbie appearance later on

_____ I understand that variable blood supply may hamper proper healing, wound breakdown may occur

_____ I understand that activities I perform may damage my surgical repair and that strict adherence to my post-op instruction is critical

_____ I understand that I am not allowed to have sexual relations and I will not engage in sexual activity for at least six (6) weeks; until cleared by Dr. Alinsod

_____ I understand that scarring from reaction to sutures, infections, keloids may occur and that all scars may not be hidden from view or may actually be more prominent depending on the healing process

_____ I understand wound revision(s) or resurfacing procedure(s) may be needed to achieve the desired look and appearance

_____ I understand that Dr. Alinsod performs revisions for $995, **within one (1) year** of his original surgery to cover OR fees. He does not charge a professional fee.

_____ I understand that consultations and revisions performed by other surgeons are my financial responsibility

_____ I understand that revisions may not be able to accomplish the cosmetic/functional goals I am seeking

_____ I understand that post-operative visits are crucial and Dr. Alinsod cannot be held responsible if he is unable to evaluate my progress

_____ I fully understand that Dr. Alinsod does not guarantee that he will be able to achieve the results I am seeking. No guarantees have been implied or given.

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SURGICAL INFORMED CONSENT

-List continued from page 8

_____ I fully understand the ramifications of a vaginoplasty that is too tight (i.e. painful intercourse, scars and bands inside the vagina, and the need for revision) and that diligent vaginal softening exercises will be needed to be performed from two (2) weeks to a month or more starting at about the sixth (6^{th}) week Post-Op depending on the size desired. Band release may also be needed.

_____ I fully understand that hymenoplasty may result in painful intercourse initially with the possibility of bleeding and hemorrhage. It is also possible that I may not bleed.

I also understand that the hymen may need to be incised to release retained fluids or for comfortable intercourse. No guarantees of bleeding during sex are given.

_____ I have reviewed all information and I understand that no guarantees have been implied and/or given to me regarding the safety and efficacy of the procedure(s); nor have any guarantees been implied and/or given in regards to results.

DISCLOSURE:

Dr. Alinsod and his staff have given me full disclosure regarding my surgery. I have received and read the following in regards to the above medical and/or aesthetic vaginal surgery(ies) and/or procedure(s):

_____ Photo and Video Consent (Attached)
_____ Mesh Information Handout
_____ Bowel Preparation Handout (Attached)
_____ Pre-Op and Post-Op Instructions (Attached)
_____ Training Day Consent (Attached)
_____ Other:_____

OPTIONS: Please initial

_____ The options of care have been fully discussed. I have had the chance to research other surgeons and surgical approaches and am aware of my options such as:

- outside consultations
- surgery or no surgery
- expectant management (wait and see)
- medical management or
- to proceed with the agreed upon surgery(ies) / procedure(s).

_____ I have elected to proceed with the surgery(ies) / procedure(s) willingly and without hesitation at the time frame of my choice; I am also aware that I reserve the right to cancel surgery(ies) / procedure(s).

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
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_____
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SURGICAL INFORMED CONSENT

OTHER CONCERNS AND DISCUSSIONS:
_____
_____

I understand **THIS IS A LEGAL DOCUMENT** that is beneficial for all parties involved and that it requires my signature of authorization, consent and acknowledgement.

Dr. Red Alinsod, South Coast Urogynecology, Inc. and/or his employee(s) reserve the right to refuse proceeding with the surgery(ies) / procedure(s) if I refuse to sign this document.

My signature below acknowledges that all Risks/Benefits/Options have been fully discussed and explained to me; I have received and reviewed all Pre-Op and Post-Op Instructions with Dr. Alinsod and/or his employee(s). I understand and accept all information, consents and instructions provided to me in its entirety. I am aware that a copy of this signed consent is available to me upon request.

PATIENT SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

PATIENT PRINTED NAME: _____

PHYSICIAN SIGNATURE: _____ _____/_____/_____ _____:_____
Red M. Alinsod, M.D., FACOG, FACS, ACGE **DATE** **TIME**

WITNESS SIGNATURE: _____ _____/_____/_____ _____:_____
DATE **TIME**

WITNESS PRINTED NAME: _____

REVIEWED_____ DATE _____ TIME _____

NO CHANGES _____ CHANGES _____

In conjunction with this surgery(ies) / procedure(s) I have received:

_____ Prescriptions required prior to surgery and post-operatively
_____ Numbing Cream
_____ Collagen Cream
_____ Estrace Cream

TODAY'S DATE: _____
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PHOTOGRAPHY AND VIDEO CONSENTS

SURGICAL DOCUMENTATION

____I **AUTHORIZE** Dr. **_____** and his Staff to take photographs or videos of my surgical procedure(s) and/or treatment. This includes:

- Pre-Operative / Pre-Treatment
- Intra-Operative / Intra-Treatment
- Post-Operative / Post-Treatment and
- Patient Chart Management

I understand that the photographs and videos are for documenting the surgery and evaluating the results of surgery. I understand that the digital photographs will be stored securely on Dr. **_____** computers and charts with full HIPPA Regulations followed.

_____ _____/_____/_____ ____:____
Signature Date Time

_____
Printed Name

_____ _____/_____/_____ ____:____
Witness Date Time

EDUCATIONAL AND MARKETING USES

Please **Initial ONE**:

____I **AUTHORIZE** Dr. **_____** to use my photographs or videos for educational and marketing purposes (various media outlets such as print, CD/DVD, or internet) in an anonymous manner and with complete confidentiality. There will be no identifying marks seen or portrayed unless approved by me. If I change my mind, I will notify Dr. Alinsod and/or his staff. I am aware that authorized use is uncompensated.
Facial photos ____ Full face ____ Sections only (please specify, i.e. eyes, mouth, full side view)

____I **DECLINE** to have my photographs or videos used for educational or marketing purposes. If I change my mind, I will notify Dr. **_____** and/or his staff.

_____ _____/_____/_____ ____:____
Signature Date Time

_____
Printed Name

_____ _____/_____/_____ ____:____
Witness Date Time