EMORY EASTSIDE MEDICAL CENTER
INFORMED CONSENT FOR VAGINAL DELIVERY

Do not sign this form until you have read it and fully understand its contents.

Patient's Name____ **Date**______________

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring this procedure is **Intrauterine pregnancy with EDC of** __________ .

2. I request **Drs.**: THE WOMEN'S GROUP OF GWINNETT as my physician and/or his associates that he may deem necessary to direct, to treat my condition, which has been explained to me.

3. The purpose and nature of the procedures are:
   a) Vaginal Exams
   b) Electronic Fetal Monitoring for fetal well-being
   c) IV Fluids for hydration and administration medications
   d) Possible use of Oxytocin to induce or augment labor
   e) Possible post delivery use of Oxytocin to control bleeding
   f) Mechanical Devices that may be required during course of labor and delivery include, but are not limited to:
      1) Internal monitoring using internal scalp electrode for infant well-being and/or internal uterine pressure catheter for maternal contractions and/or amnioinfusion. (Amnioinfusion may be necessary to decrease risk from meconium or cord compression)
      2) Devices used to facilitate delivery may include, but are not limited to, Vacuum Extractor and/or Forceps.

4. **Material Risk associated with labor and vaginal delivery include but are not limited to:**
   a. Possible need for immediate surgery or other additional surgery, which might include a hysterectomy (removal of the uterus, fallopian tubes and/or ovaries);
   b. Possible injury to bowel, bladder or ureter or other pelvic or abdominal structure;
   c. Possible fistula formation (an opening between bowel, bladder, ureter, vagina and/or skin) caused by an injury to the bowel, bladder, or ureter;
   d. Possible injury to the baby;
   e. Possible formation of blood clots;
   f. Possible emboli (clots of blood or other material that might travel to other parts of the body);
   g. Possible blood loss necessitating transfusion which carries the risk of exposure to AIDS, hepatitis or other infectious diseases;
   h. Infection
   I. Allergic reaction
   j. Disfiguring scar, loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, brain damage, cardiac arrest, or death.

5. Practical alternatives: **None**

6. The likelihood of success of the above procedure is: ( ) good; ( ) fair; ( ) poor.

I understand that the physician and medical personnel will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the above procedure.

I understand that the practice of medicine is not an exact science and that **no guarantees or assurances have been made to me** concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures as they deem necessary or appropriate.

I also consent to diagnostic studies, test, anesthesia, x-ray examinations and other treatment or courses of treatment relating to the diagnosis or procedures described herein.

By signing this form, I acknowledge that I have read or had this form read and/or explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed below relating to the procedure described herein.

I voluntarily consent to allow :Drs. THE WOMEN'S GROUP OF GWINNETT or any physician designated or selected by him or her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

____
Signature of Physician

____
Signature of Patient or Patient's Representative

__________________________ am/pm
Date Time

____
Relationship of Representative to patient

____
Reason patient is unable to sign

Reaffirmed on admission: Date:__________ Patients Initials__________

Signature of Witness:__________________________

sagdel