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**Her Option<sup>®</sup> Office Cryoablation Therapy**  
Informed Consent

I, \_\_\_\_\_, hereby authorize Robert Bass MD to perform cryoablation of my uterus. This procedure has been clearly explained to me. The alternatives to this procedure have been discussed. The physician has answered my questions to my satisfaction. I understand that the purpose of cryoablation is to cause the sloughing off of the endometrium (the lining of the uterus). I understand that I may feel discomfort and/or cramping during the procedure. I understand that certain complications can sometimes result from cryoablation. These complications include, but are not limited to, bleeding, uterine scarring, uterine perforation with injury to inter-abdominal contents, and infection of the uterus or other pelvic organs. Some complications may result in a need for a hysterectomy.

The medical literature has indicated that the general success rate for this procedure in treating abnormal vaginal bleeding is approximately 90 percent. Twenty to thirty percent (20-30%) of the patients will experience total resolution of their periods. Cryoablation may not decrease menstrual cramps or pain.

Cryoablation is not a form of birth control. Pregnancy is still a possibility after cryoablation. Effective birth control continues to be important after this procedure. Should pregnancy occur, there is a higher than normal chance of ectopic (tubular) pregnancy, miscarriage, premature delivery or birth defects that can be dangerous for both mother and fetus.

Following the procedure, I have been informed that I can expect as a normal result of the procedure a heavy watery discharge for up to 1-3 weeks. I understand that intercourse should be avoided until the discharge stops. I understand that my first menstrual cycle after this procedure may be heavier than normal with passage of tissue.

I have read the above and I fully understand the nature, purpose, risk and alternatives to this procedure and I am willing to undergo the procedure.

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
PATIENT

\_\_\_\_\_  
DATE