

## Informed Consent Form

### Hemorrhoidectomy for Thrombosed External Hemorrhoids

Patient: \_\_\_\_\_

Date: \_\_\_\_\_

1. I hereby authorize Dr. \_\_\_\_\_ to perform the procedure known as excision (hemorrhoidectomy) of a thrombosed external hemorrhoid.
2. I understand that this is a procedure performed, under local anesthesia, on the tissues in my anal area. I understand that the procedure will attempt to remove the blood clot causing my discomfort. The surgery will remove the hemorrhoidal blood vessels that have become clotted and attempt to prevent further clotting or disease. I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
3. My doctor has explained to me that this procedure is generally safe, but that certain risks accompany any surgical procedure. Risks associated with the excision of a thrombosed external hemorrhoid include the following:
  - Bleeding, sometimes requiring transfusion or hospitalization
  - Pain associated with the surgery or the healing process
  - Excessive scarring or narrowing of the anal canal after the surgery
  - Allergic reaction to the numbing medications or surgical instruments
  - Infection in the anal tissues or throughout the body
  - Damage to the anal muscles, causing inability to control bowel movements
  - Rare, unusual reactions, including possible death following any surgical procedure
4. I understand that there are alternatives to this procedure, including simple incision and drainage of the clot, laser destruction of the tissues or observation until the clot resolves. I understand that I can refuse this procedure.
5. I understand that unforeseen conditions may alter the planned procedure. I give permission to my doctor to alter the procedure if necessary (such as to cauterize tissues to control bleeding) or to administer additional anesthetics or other medications if I should need them for the completion of my procedure.
6. I have read this form and the other information forms given to me by my doctor. I have had my questions answered to my satisfaction.

Witness: \_\_\_\_\_ Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Minor: \_\_\_\_\_ Parent: \_\_\_\_\_

Adapted with permission from Zuber TJ. Office procedures. Baltimore: Lippincott Williams & Wilkins, 1999.