CONSENT FOR CRYOTHERAPY

I, (print or type name) _____, give my consent for cryotherapy. Cryotherapy is a form of treatment in which a freezing probe is applied to the cervix or other areas to accomplish the destruction of abnormal cells and the regrowth of normal tissue.

I acknowledge that no guarantees have been made or implied to me as to the result of this treatment. Follow-up evaluations for about two years should be anticipated.

I understand that during or after the procedure one or more of the following might occur:

- Dizziness
- Fainting
- Cramping
- Mild bleeding
- Vaginal discharge
- Infection

I have had a chance to ask questions and have had my questions answered.

Date: _____ Client Signature: _____

Date: _____ Parent/Guardian Signature: _____

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If translation of CONSENT FOR CRYOTHERAPY was required:

- A translator was offered to the client. □ yes □ no
- The client chose to use her own translator. □ yes □ no
- This form has been orally translated to the client in the client's spoken language.
- Language translated: _____
- Translation provided by: _____
  (print or type name of translator)
- Translator employed by, or relationship to client: _____
- Date: _____ Translator Signature: _____

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- The client has read this form or had it read to her by a translator or other person.
- The client states that she understands this information.
- The client has indicated that she has no further questions.

Date: _____ Staff Signature: _____

Clinician Signature: _____