Learning Consent for
Cervical/Fetal Membrane Stripping/Sweeping/Separation

_____ _____
Patient Name Medical Record #

1) _____ has explained in lay terms to me that
Clinician Name

2) I have the condition _____
To be filled in by patient in lay terms

3) and that cervical/fetal membrane stripping/sweeping/separation has been recommended.

4) The following has been explained to me in understandable/lay terms:
a) its purpose and nature
b) intended benefits and most concerning risks
c) the likely results if I don't have this procedure
d) alternative treatments and their benefits and risks
e) there is no proven way to prevent pain or discomfort from this procedure

5) The most likely and severe risks are:
_____
To be filled in by patient in lay terms

6) I understand what has been discussed with me as well as the contents of this form.

7) I have been given the opportunity to ask questions and have received satisfactory answers.

If you have not had all your questions answered to your satisfaction, DO NOT sign this form.

8) I voluntarily consent to the performance of this procedure as described by my clinician or his or her staff.

_____ _____
Patient Signature Date

_____
Witness

_____
Clinician