Consent for Methotrexate Administration for the treatment of Ectopic (tubal) Pregnancy

I, _____ herby authorize Dr._____
And his/her associates or other designated physicians to provide methotrexate administration as medically indicated for the treatment of ectopic (tubal pregnancy.

Methotrexate therapy for the treatment of ectopic (tubal) pregnancy has been recommended for me. The nature and purpose of this therapy has been fully explained to me. The possible benefits, risk and alternatives of the methotrexate therapy and other available treatments have also been explained to me.

I understand:

1. There are two kinds of treatment for ectopic (tubal) pregnancy:
    - Surgery with removal of the fallopian tube, or removal of the tubal pregnancy from the tube.
    - Methotrexate therapy
2. Methotrexate is a medication given by injection that stops cell growth of rapidly dividing cells. Most often this will end the pregnancy.
3. In order to make sure the methotrexate therapy has worked; it is important to have all blood work that is ordered.
4. Sometimes, more than one injection may be needed to be given to make sure the therapy has worked.

I understand that other than expected risks, complications may occur and that no guarantees have been made to me about the result of this treatment. My physician has discussed the nature of the therapy and its risk and benefits. I have read the information on the discharge instructions. I understand all of the instructions I must follow after receiving methotrexate therapy. I understand what has been discussed with me and I have been given the chance to ask questions and have received satisfactory answers.

I also consent to the performance of those procedures, and administration of blood products or medications which may be necessary should an unanticipated emergency arise.

BY MY SIGNATURE BELOW, I CONSENT TO THE PROCEDURE(S) DESCRIBED ABOVE. I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I HAVE HAD THE OPPURTUNITY TO ASK ANY QUESTIONS AND ALL MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient or legal agent signature_____Date_____

Relationship of legal Agent_____

Witness signature_____Date_____